Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

Tel: **705-327-9127** Fax: **705-330-3224**

REQUEST FOR

X-RAY Examination

PATIENT INFORMATION	MRN N⁰.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**
Last Name	First Name		☐ M ☐ F
Date of Birth (D/M/Y)	Health Card N⁰.	WSIB N⁰.	3rd Party Ins. N⁰.
Address	City		Postal Code
Email Address	Contact Number		**OK to leave voice mail message**

Patient is able to give consent for this procedure: ☐ Yes ☐ No

Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ **SDM Name:** ☐ **SDM Contact Information:**

☐ **Patient requires assistance to complete this imaging exam,** *e.g. mobility, translation* **Please Specify:**

Head & Neck

- ☐ SKULL
- ☐ MANDIBLE
- ☐ TMJ JOINTS
- ☐ ORBITS
- ☐ NASAL BONES
- ☐ FACIAL BONES
- ☐ SOFT TISSUE NECK

Chest & Abdomen

- ☐ CHEST 2 VIEWS (PA & Lat)
- ☐ RIGHT RIBS (Incl. Chest PA View)
- ☐ LEFT RIBS (Incl. Chest PA View)
- ☐ STERNUM
- ☐ S-C JOINTS
- ☐ ABDOMEN/KUB
- ☐ ABDOMEN 3 VIEWS (Incl. PA CXR)

Gastrics

Must be ordered by a surgeon.

- ☐ UPPER GI SERIES
- ☐ BARIUM SWALLOW
- ☐ SMALL BOWEL FOLLOW-THRU

Lower Extremities

R	L	
☐	☐	HIP
☐	☐	FEMUR
☐	☐	KNEE
☐	☐	PATELLA
☐	☐	TIB-FIB
☐	☐	ANKLE
☐	☐	CALCANEUS
☐	☐	FOOT
☐	☐	TOE ☐1 ☐2 ☐3 ☐4 ☐5

Ortho Examinations (Requires Ortho Referral)

- ☐ ORTHOROENTGENOGRAM
- ☐ BILATERAL STANDING FEET & ANKLES
- ☐ VALGUS STRESS VIEW OF THE KNEES

R	L
☐	☐

Upper Extremities

R	L	
☐	☐	CLAVICLE
☐	☐	A.C. JOINTS
☐	☐	SCAPULA
☐	☐	SHOULDER
☐	☐	HUMERUS
☐	☐	ELBOW
☐	☐	FOREARM
☐	☐	WRIST
☐	☐	SCAPHOID
☐	☐	HAND
☐	☐	FINGER ☐1 ☐2 ☐3 ☐4 ☐5

Spine & Pelvis

- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ S.I. JOINTS
- ☐ SACRUM & COCCYX
- ☐ PELVIS
- ☐ SCOLIOSIS 1 VIEW (AP)
- ☐ SCOLIOSIS 2 VIEWS (AP & Lat)
- ☐ SKELETAL SURVEY (Metastases)
- ☐ ARTHRITIC SURVEY
- ☐ SKELETAL SURVEY (non-trauma)

OTHER EXAM NOT LISTED:

RELEVANT CLINICAL HISTORY FOR EXAM:

Physician's Name (Please PRINT clearly)		Physician's Signature
Phone	**CPSO#**	

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.