Soldiers' MEMORIAL HOSPITAL Orillia

REQUEST FOR
X-RAY Examination

Tel: **705-327-9127** Out-Patient Fax: **705-330-3224** In-Patient Fax: **705-325-0582**

PATIENT INFORMATION | MRN N⁰. | Isolation Status

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ED ☐ AHF

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 1 VIEW
- ☐ CHEST 2 VIEWS (PA & Lat)
- ☐ CHEST 3 VIEWS (Inspiration & Expiration)
- ☐ CHEST/ABDO 1 VIEW (Foreign Body)
- ☐ RIGHT RIBS (Incl. Chest PA View)
- ☐ LEFT RIBS (Incl. Chest PA View)
- ☐ STERNUM
- ☐ S-C JOINTS
- ☐ ABDOMEN/KUB
- ☐ ABDOMEN 2 VIEWS (Incl. PA CXR)

Lower Extremities

R	L	
☐	☐	HIP
☐	☐	FEMUR
☐	☐	KNEE
☐	☐	PATELLA
☐	☐	TIB-FIB
☐	☐	ANKLE
☐	☐	CALCANEUS
☐	☐	FOOT
☐	☐	TOE

☐1 ☐2 ☐3 ☐4 ☐5

Ortho Examinations (Must Have Ortho Referral)
- ☐ ORTHOROENTGENOGRAM
- ☐ BILATERAL STANDING FEET & ANKLES

Ortho Assessment (Ortho Specialist Only)
- ☐ R ☐ L SHOULDER ARTHROPLASTY
- ☐ R ☐ L HIP (includes orthoroentgenogram)
- ☐ R ☐ L KNEE (includes orthoroentgenogram)
  - ☐ ADD VALGUS KNEE
- ☐ R ☐ L PATELLAR SERIES (includes orthoroentgenogram)

Upper Extremities

R	L	
☐	☐	CLAVICLE
☐	☐	A.C. JOINTS
☐	☐	SCAPULA
☐	☐	SHOULDER
☐	☐	HUMERUS
☐	☐	ELBOW
☐	☐	FOREARM
☐	☐	WRIST
☐	☐	SCAPHOID
☐	☐	HAND
☐	☐	FINGER

☐1 ☐2 ☐3 ☐4 ☐5

☐ BONE AGE

Spine & Pelvis
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ S.I. JOINTS
- ☐ SACRUM & COCCYX
- ☐ PELVIS
- ☐ SCOLIOSIS 1 VIEW (AP)
- ☐ SCOLIOSIS 2 VIEWS **(Must be ordered by Specialist)**

Must Be Scheduled

Skeletal Survey
- ☐ ARTHRITIC
- ☐ INFANT
- ☐ METASTATIC

Gastrics (Must be ordered by a Surgeon)
- ☐ LIMITED PEDIATRIC UPPER GI
- ☐ SMALL BOWEL FOLLOW-THRU

OTHER EXAM NOT LISTED:

CLINICAL QUESTION AND RELEVANT CLINICAL INFORMATION
(Must be provided and must be specific)

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

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