Huron Health SYSTEM

ALEXANDRA MARINE & GENERAL HOSPITAL
120 Napier Street, Goderich, Ontario N7A 1W5
Phone (519) 524 8323; **Fax (519) 524 8532**

Office Use Only

Appointment Date and Time: _____

Patient Health Record #: _____

Medical Imaging Requisition

Patient Name: _____
Date of Birth (dd/mm/yyyy): _____
Telephone #: _____

Alternate Phone #: _____
Health Card #: _____
WSIB#: _____

Ordering Practitioner Instructions:

- For General X-rays, Gastrics, Ultrasound Mammography, fax to 519-524-8532
- Call Medical Imaging to inform if Stat request

Isolation: ❑ Contact ❑ Droplet ❑ Airborne

Patient Instructions:

- Once requisition is received in MI booking will contact with the appointment date & time or call 519-524-8323 x5474 to book
- Health card is required on the date of your exam

X-RAY EXAMS

Abdomen/Pelvic:
❑ Single view supine/KUB
❑ Acute series supine/erect
❑ Pelvis

Head & Neck
❑ Skull
❑ TM Joints
❑ Facial Bones
❑ Nasal Bones
❑ Mandible
❑ Neck for Soft Tissues

Chest
❑ Chest PA & Lat
❑ Ribs Right Left Bilateral
❑ Sternum

Spine**
❑ Cervical Spine
❑ Thoracic Spine
❑ Lumbar Spine
❑ SI Joints

Please check Left or Right

Upper Extremities	**Lt**	**Rt**
❑ Clavicle	❑	❑
❑ AC Joints	❑	❑
❑ Shoulder	❑	❑
❑ Scapula	❑	❑
❑ Humerus	❑	❑
❑ Elbow	❑	❑
❑ Forearm	❑	❑
❑ Wrist	❑	❑
❑ Scaphoid	❑	❑
❑ Hand	❑	❑
❑ Finger 1 2 3 4 5	❑	❑

Lower Extremities	**Lt**	**Rt**
❑ Hip	❑	❑
❑ Femur	❑	❑
❑ Knee	❑	❑
❑ Tib. & Fib.	❑	❑
❑ Ankle	❑	❑
❑ Foot	❑	❑
❑ Calcaneus	❑	❑
❑ Toe 1 2 3 4 5	❑	❑

****If ordering a Spinal Xray, please check appropriate box in Clinical Information section below.**

❑ **Other X-ray exams**_____

EXAMS Requiring an Appointment

Fax Requisition to 519-524-8532

G.I. TRACT
❑ Barium Swallow/Upper G.I Study
❑ Modified Swallowing study – coordinated with speech path.
❑ Small Bowel Follow Through
❑ Double Contrast Barium Enema

ULTRASOUND
❑ OB U/S for IPS (11-13 weeks)
❑ OB U/S for MSS/Dating (less than 16 weeks)
❑ OB U/S – ROUTINE (>18 weeks)
❑ OB U/S – High Risk (Complications): _____
❑ Abdomen - Complete
❑ Abdomen – Limited (Specify):_____
❑ KUB (kidney/ureter/bladder)
❑ Bladder
❑ Renal
❑ Pelvis – Complete
❑ Scrotal
❑ Popliteal Fossa ❑ Right ❑ Left
❑ Shoulder ❑ Right ❑ Left ❑ Bilateral
❑ Thyroid
❑ Venous Doppler ❑ Right ❑ Left
❑ Arterial Doppler ❑ Right ❑ Left
❑ Carotid Doppler
❑ Other Ultrasound Exams: _____

❑ **MAMMOGRAPHY**

Clinical Info (required): ***URGENT*** ***ELECTIVE***

Additional Copies to:

Suspected Pathology:
❑ Trauma ❑ Tumour ❑ Infection
❑ Spinal stenosis/cauda equine syndrome
❑ Nerve root compression
❑ Ankylosing spondylitis/inflamm. condition
❑ Congenital/developmental abnormality

Department use only:
Tech initials _____
❑ DOB checked
❑ Pt not Pregnant
❑ Lead used

REFERRING PRACTITIONER:
Practitioner's Name (Print) _____
Tel: _____ Fax: _____
Practitioner's Signature: _____

Address: _____
Billing No: _____ CPSO/CNO/Reg. No:_____
Date(dd/mm/yyyy): _____

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