

An appointment is required for all exams

- Patient will book (call 519-235-5163)
- Diagnostic Imaging Dept. to book

Appt Date: _____ Time: _____

- WSIB Diabetic Hoyer Lift

- ER PATIENT
- RETURN TO ER
- FOLLOW UP WITH FAMILY PHYSICIAN

Patient Name

D.O.B. (dd/mm/yyyy)

Health Card Number

Patient Phone Number

CLINICAL INFORMATION (MANDATORY):

AN APPOINTMENT IS REQUIRED FOR ALL EXAMS – NO EXAMINATION WILL BE PERFORMED WITHOUT THIS REQUISITION.

X-RAY EXAMS

ABDOMEN

- Single view supine/KUB
- Acute series supine/Erect

CHEST

- Chest PA & Lat
- Ribs Right Left Bilateral

HEAD & NECK

- Facial Bones
- Mandible
- Neck for Soft Tissues

SPINE & PELVIC

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Pelvis

UPPER EXTREMITIES

- | | | |
|---|--------------------------|--------------------------|
| | Rt | Lt |
| <input type="checkbox"/> Clavicle | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> AC Joints | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Scapula | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Humerus | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Scaphoid | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Finger 1 2 3 4 5 | <input type="checkbox"/> | <input type="checkbox"/> |

LOWER EXTREMITIES

- | | | |
|--|--------------------------|--------------------------|
| | Rt | Lt |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Femur | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tib. & Fib. | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Calcaneus | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Toe 1 2 3 4 5 | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other X-Ray: _____ | | |
| <input type="checkbox"/> ECG | | |

BONE DENSITOMETRY

Please see instructions on reverse.

- Bone Mineral Density
- Last exam date and location: _____

ULTRASOUND

Please see instructions on reverse.

- OB -Dating (less than 16 weeks) LMP: _____
- OB -IPS/eFTS (North York eFTS req must accompany this req)
- OB -Routine (>20 weeks)
- OB -High Risk
- Abdomen -Complete
- Abdomen -Limited (specify): _____
- Aorta
- Bladder
- Renal
- Pelvis - proceed to transvaginal if appropriate
- Thyroid
- Scrotal
- Shoulder: Right Left Bilateral
- Popliteal Fossa: Right Left Bilateral
- DVT Leg: Right Left Bilateral
- Carotid Doppler - Please include list of medications.
- Other U/S exam (specify): _____

Ordering Physician/N.P.
Name (Printed)

Physician/N.P.
Signature

Registration Number

Date (dd/mm/yyyy)

Additional Copies

**Important patient ➡
information on reverse**

South Huron Hospital – Diagnostic Imaging Department
Phone: 519-235-5163

- **Please bring your health card with you to the hospital on the date of your exam, and if you have it, a copy of your requisition.**
- **Please check in at registration 10 minutes prior to your appointment time.**

X-RAY PREPARATIONS (Please check appropriate box below)

BONE MINERAL DENSITY

- Please wear clothing with no buttons or zippers & no underwire bra.
- No calcium on day of examination.

ULTRASOUND PREPARATIONS (Please check appropriate box below)

ABDOMEN (Complete or Limited Study)

- Have nothing to eat or drink after midnight.

PELVIC EXAMINATION (Male or Female)

- Have 40 oz. (1200ml) of water consumed and finished 1 hour prior to your appointment time.
- DO NOT empty your bladder until after your examination.

OBSTETRICAL EXAMINATION

- Preparation the same as Pelvic Examination above.

ALL OTHER EXAMINATIONS

- No preparation required.