Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5
T 519-524-8323 | F 519-524-8504

Medical Imaging Requisition

Patient Name: _____
Date of Birth (dd/mm/yyyy): _____
Telephone #: _____
Patient will be notified by email, if email provided.
(Patient understands email may not allow secure communication)

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

Ordering Practitioner Instructions:

- For General X-ray Exams, have patient call 519-524-8323 ext. 5474
- For Gastrics, Ultrasound Mammography, fax to 519-524-8532
- Call Medical Imaging to inform if Stat request

Patient Instructions:

- Health card and this requisition are required on the date of your exam

Isolation: ❑ Contact ❑ Droplet ❑ Airborne

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**
❑ **BONE MINERAL DENSITY**
(BMD at Clinton and Exeter Hospitals ONLY)

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

_____ Practitioner's Signature
_____ Practitioner's Name (Print)
_____ Date (dd/mm/yy)
Fax #: _____
Phone #: _____