Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5
T 519-524-8323 | F 519-524-8532

# 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

**REFERRING PHYSICIAN:**
Practitioner's Name (Print) _____ Address: _____
Tel: _____ Fax: _____ Billing No: _____
Physician's Signature: _____ Date(dd/mm/yyyy): _____