CHATHAM-KENT
Health Alliance

80 Grand Ave., W.
Chatham, Ontario N7L 1B7
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Name: LAST FIRST MIDDLE INITIAL

Date of Birth: YYYY MM DD

Address:

City: Prov:

Telephone #:

Health Card #:

Date Received: YYYY MM DD Booked:

Physician Name:

Address:

Postal Code: Phone:

Copy Reports to:

DIAGNOSTIC IMAGING DEPARTMENT REQUISITION

☐ Outpatient ☐ Inpatient Room_____ ☐ ED Patient ☐ Portable ☐ Clinic ☐ Wheelchair ☐ Stretcher ☐ Precautions_____

CLINICAL RELEVANT HISTORY (required)

XRAY (weight limit 450 lbs)

ABDOMEN
- ☐ Single View (KUB) - Supine
- ☐ Acute Series - Supine & Erect

SPINE
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar / Sacral Spine
- ☐ Sacrum / Coccyx
- ☐ SI Joints ☐ Scoliosis

CHEST
- ☐ Visa PA ☐ Single View
- ☐ PA & Lateral Chest
- ☐ Ribs ☐ Left ☐ Right
- ☐ Soft Tissue Neck

HEAD
- ☐ Skull
- ☐ Sinuses
- ☐ Facial Bones
- ☐ Orbits ☐ MRI-FB
- ☐ Nasal Bones
- ☐ Mandible
- ☐ TM Joints

EXTREMITIES

Clavicle	☐ Left	☐ Right
AC Joints	☐ Left	☐ Right
Shoulder	☐ Left	☐ Right
Scapula	☐ Left	☐ Right
Humerus	☐ Left	☐ Right
Elbow	☐ Left	☐ Right
Forearm	☐ Left	☐ Right
Wrist	☐ Left	☐ Right
Scaphoid	☐ Left	☐ Right
Hand	☐ Left	☐ Right
Thumb	☐ Left	☐ Right
Finger No.____	☐ Left	☐ Right

- ☐ AP Pelvis only
- ☐ Pelvis-Left Hip ☐ Pelvis-Right Hip
- ☐ Pelvis - Bilateral Hips
- ☐ Leg Length

Hip	☐ Left	☐ Right
Femur	☐ Left	☐ Right
Knee	☐ Left	☐ Right
Knee/Patella	☐ Left	☐ Right
Tibia/Fibula	☐ Left	☐ Right
Ankle	☐ Left	☐ Right
Foot	☐ Left	☐ Right
Toe No._____	☐ Left	☐ Right
Calcaneus	☐ Left	☐ Right

ULTRASOUND (weight limit 450 lbs) by appointment

- ☐ Abdomen ☐ Liver follow up
- ☐ Aorta ☐ Appendix
- ☐ Renal ☐ Gallbladder
- ☐ Bladder
- ☐ Post Void Residual ☐ Other_____
- ☐ Thyroid _____
- ☐ Neonatal Head
- ☐ Hernia specify_____
- ☐ Testicular
- ☐ Pelvis ☐ Male
  ☐ Female - will proceed to ☐ TV Transvaginal Ultrasound if necessary
- ☐ Shoulder ☐ Left ☐ Right
- ☐ Popliteal Fossa ☐ Left ☐ Right
- ☐ Breast ☐ Left ☐ Right
- ☐ Soft Tissue Mass_____
- ☐ Biopsy specify_____
- ☐ Echocardiogram

VASCULAR U/S
- ☐ Ankle Brachial Index (ABI)

Lower Extremity Doppler
- Arterial ☐ Left ☐ Right ☐ Bilateral
- Venous ☐ Left ☐ Right ☐ Bilateral

Upper Extremity Doppler
- Arterial ☐ Left ☐ Right ☐ Bilateral
- Venous ☐ Left ☐ Right ☐ Bilateral
- ☐ Carotid Doppler

PREGNANCY U/S EDC/LMP_____

Requested Imaging Date
from_____ to_____

- ☐ Dating
- ☐ Focused_____
- ☐ IPS
- ☐ Anatomy
- ☐ Twins
- ☐ Biophysical Profile
- ☐ Cervical Length

INTERVENTIONAL by appointment

- ☐ PICC LINE ☐ Other
- ☐ Hysterosalpingography
- ☐ Jt Injection_____
- ☐ Arthrogram_____

NUCLEAR MEDICINE (weight limit 375 lbs) by appointment

- ☐ Bone Scan
- ☐ Gallium Scan
- ☐ White Cell Scan
- ☐ RBC Liver Scan For Hemangioma
- ☐ Lung Scan
- ☐ Kidney ☐ Renogram - Function ☐ Renogram - Hypertension ☐ Lasix Renogram
- ☐ Cardiac Wall Motion/Ejection fraction
- ☐ Thyroid Uptake & Scan (2 day test)
- ☐ Iodine Therapy
- ☐ Gastric Emptying Scan
- ☐ Meckel's Scan
- ☐ HIDA Scan
- ☐ Nuclear Stress Test
- ☐ Persantine Stress Test
- ☐ Other_____

BMD (weight limit 300 lbs) by appointment

- ☐ Bone Mineral Densitometry
- ☐ High Risk Bone Mineral Density

MAMMOGRAPHY (weight limit 325 lbs for chair) by appointment

- ☐ Diagnostic Bilateral ☐ Left ☐ Right
- ☐ Ontario Breast Screening Program
- ☐ Galactogram ☐ Left ☐ Right
- ☐ Biopsy ☐ Left ☐ Right

GASTRIC STUDIES (weight limit 375 lbs) by appointment

- ☐ Upper GI Series
- ☐ Esophagus/Barium Swallow
- ☐ Small Bowel Follow Through
- ☐ MBS - Modified Barium Swallow
- ☐ Double Contrast Barium Enema
- ☐ Single Contrast Barium Enema

UROLOGY (weight limit 350 lbs) by appointment

- ☐ IVP
- ☐ Voiding Cystogram
- ☐ Stress Cystogram
- ☐ Catheter Cystogram

- ☐ KUB no appointment required

*****PREVIOUS RELEVANT EXTERNAL REPORTS MUST BE ATTACHED*****

Ordering Physician Signature (required): _____

Printed Physician's Name: _____

Date: YYYY MM DD

INCOMPLETE REQUESTS WILL BE RETURNED-RESULTING IN DELAY/CANCELLATION OF THE PROCEDURE