Middlesex Hospital Alliance
Diagnostic Imaging

☐ Strathroy Middlesex General Hospital

☐ Four Counties Health Services

For appointments, please fax completed requisition to:

Fax: 519-245-3843

Phone: 519-246-5911

Toll Free: 1-866-269-8384

Patient's Last name **First Name**

Address

Phone # **DOB** YYMMDD

Health Card # **Mobility Issues/Special Needs**

APPOINTMENT DATE

_____ ☐ AM ☐ PM

TIME

Important: For safety reasons, young children will not be permitted in the room during your examination

X-RAY

Hours: FCHS: 0800-1730hrs M-F SMGH 0800-1900 M-F

CHEST & ABDOMEN

- ☐ Chest PA & LAT
- ☐ Ribs ☐RT ☐LT
- ☐ KUB/Abdomen (1 View)
- ☐ Abdomen Series (3 Views)

HEAD & NECK

- ☐ Nasal Bones
- ☐ Facial Bones
- ☐ Soft Tissue of Neck
- ☐ Orbits
- ☐ Orbits pre MRI
- ☐ Mandible
- ☐ TM Joints

SPINE & PELVIS

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar/Sacral Spine
- ☐ Sacrum & Coccyx
- ☐ SI Joints
- ☐ Pelvis
- ☐ Hips to Ankle Bilat (For Ortho only)

LOWER EXTREMITIES

R	L	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tibia & Fibula
☐	☐	Ankle
☐	☐	Foot
☐	☐	Calcaneus
☐	☐	Heal Spur (1View)
☐	☐	Toes 1 2 3 4 5

UPPER EXTREMITIES

R	L	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Digits 1 2 3 4 5

Other, please specify: _____

All TESTS BELOW REQUIRE AN APPOINTMENT

ULTRASOUND

- ☐ Abdomen
- ☐ Aorta
- ☐ Kidneys
- ☐ Kidneys & Bladder
- ☐ Pelvis
- ☐ Scrotal
- ☐ Thyroid ☐ Neck
- ☐ Hernia Inguinal ☐ RT ☐ LT
- ☐ Hernia Abdomen Wall
- ☐ Soft Tissue Mass:

OBSTETRICAL

Date of LMP: _____

- ☐ OB Dating
- ☐ OB 11-13.6 wks (eFTS)
- ☐ OB Routine 18-20 wks
- ☐ OB Twins

MUSKULOSKELETAL

- ☐ Shoulder ☐ RT ☐ LT ☐ Bilat
- ☐ Other: _____

VASCULAR

- ☐ Carotid
- ☐ Leg Venous Doppler ☐ RT ☐ LT ☐ Bilat
- ☐ Arm Venous Doppler ☐ RT ☐ LT ☐ Bilat

FCHS ONLY

- ☐ Leg Arterial Doppler ☐ RT ☐ LT ☐ Bilat
- ☐ Arm Arterial Doppler ☐ RT ☐ LT ☐ Bilat

REASON FOR EXAM / CLINICAL HISTORY

Stat Contact Information: _____

SMGH ONLY

BMD (>18yrs <300lbs)

☐ **Repeat** Previous When:

Where:

☐ **Baseline** (NO previous)

Treatment for bone loss: **Start Date:**

Drug:

Corticosteroid >3 months? ☐ Yes ☐ No

Start Date: March 31 2020

Fragility fracture after 40? ☐ Yes ☐ No

GASTRICS / FLUOROSCOPY

- ☐ Upper G.I Series/Barium Swallow
- ☐ Small Bowel Follow Through
- ☐ Voiding Cystogram ☐ Stress Cystogram
- ☐ Modified Barium Swallow with referral to SLP

ECHOCARDIOGRAM

☐ **Routine Echocardiogram** (>16yr.old)

Providers Name:
(Please print clearly)

Billing #:

OFFICE STAMP

Address/Phone/Fax:

Providers Signature:

CC:

Date (yyyy-mmm-dd):

INCOMPLETE, ILLEGIBLE, AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED