Reset

DIAGNOSTIC IMAGING - RADIOLOGY

X-RAY

QHC Quinte Health Care	MD Name:	Patient Name:
	Signature:	DOB:
	MD Phone:	HCN:
	Date: (d/m/y)	Home Phone:
FAX ALL REQUISITIONS TO: 613-969-5561	Copies to:	Cell Phone
	WSIB #:	Address:

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:

PRIORITY: ☐ Urgent ☐ Non-Urgent

PREFERRED HOSPITAL: ☐ BGH ☐ TMH ☐ PEC ☐ NHH

X-RAY

CHEST

- ☐ Chest-Routine
- Ribs ☐ R ☐ L
- ☐ S.C. Joints
- ☐ Sternum
- ☐ Thoracic Inlet

ABDOMEN

- ☐ Acute Abdomen
- ☐ Abdomen 1 View

HEAD & NECK

- ☐ Facial Bones
- ☐ Mandible
- ☐ Orbits for MRI
- ☐ Skull
- ☐ Soft Tissue Neck

SKELETAL SURVEY

- ☐ Arthritic
- ☐ Bone Age
- ☐ Metastatic

SPINE & PELVIS

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Pelvis
- Hip ☐ R ☐ L
- ☐ Sacrum/Coccyx
- ☐ S.I. Joints
- ☐ Scoliosis

UPPER EXTREMITIES

- ☐ A.C. Joints
- ☐ R ☐ L Clavicle
- ☐ R ☐ L Shoulder
- ☐ R ☐ L Scapula
- ☐ R ☐ L Humerus
- ☐ R ☐ L Elbow
- ☐ R ☐ L Forearm
- ☐ R ☐ L Wrist
- ☐ R ☐ L Hand
- ☐ R ☐ L Fingers ☐

LOWER EXTREMITIES

- ☐ R ☐ L Femur
- ☐ R ☐ L Knee
- ☐ R ☐ L Tib/Fib
- ☐ R ☐ L Ankle
- ☐ R ☐ L Foot
- ☐ R ☐ L Calcaneus
- ☐ R ☐ L Toes ☐

BARIUM STUDIES

☐ Barium Swallow Clinical: ☐ Upper GI Series Prev. Endoscopy Date: ☐

☐ Cookie Swallow Study - SLP

DEPARTMENT USE ONLY:

☐ BGH ☐ TMH ☐ PEC ☐ NHH

Appointment Date & Time:

TECHNOLOGIST USE ONLY

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613-969-5561

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