LWHA DIAGNOSTIC IMAGING REQUISITION

☐ WINGHAM – Tel: 519-357-3210, Ext. 5228
Fax: 519-357-3688

☐ LISTOWEL – Tel: 519-291-3125, Ext. 6227
Fax: 519-291-2813

Listowel Wingham HOSPITALS ALLIANCE
Together. Leading Care. Better health.

☐ E.R. Patient PATIENT NAME:

☐ Return to E.R. D.O.B.

☐ Follow up with Family Physician HEALTH CARD NO.

APPOINTMENT DATE

PLEASE CALL FOR APPOINTMENT TIMES
ALL PATIENTS TO ARRIVE 15 MINUTES EARLY FOR APPOINTMENT
MUST HAVE REQUISITION AND HEALTH CARD FOR SERVICE

☐ X-RAY ☐ MAMMOGRAPHY(LMH)

HEAD
- ☐ Skull
- ☐ Facial Bones
- ☐ Mandible
- ☐ Nasal Bones
- ☐ Sinuses
- ☐ Orbits
- ☐ TM Joints
- ☐ Soft Tissue Neck

CHEST
- ☐ Chest
- ☐ Ribs RT LT
- ☐ Sternum

ABDOMEN
- ☐ Abdomen 3V
- ☐ Abdomen 1V / KUB

SPINE AND PELVIS
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Sacral Spine
- ☐ Sacrum & Coccyx
- ☐ Sacro-Iliac Joints
- ☐ Pelvis

☐ Other Exam Details

UPPER	*CIRCLE*	
☐ A.C. Joints	RT	LT
☐ Clavicle	RT	LT
☐ Shoulder	RT	LT
☐ Scapula	RT	LT
☐ Humerus	RT	LT
☐ Elbow	RT	LT
☐ Forearm	RT	LT
☐ Hand	RT	LT
☐ Finger	RT	LT
☐ Thumb	RT	LT
☐ Wrist	RT	LT
☐ Scaphoid	RT	LT

LOWER	*CIRCLE*	
☐ Hip	RT	LT
☐ Femur	RT	LT
☐ Knee	RT	LT
☐ Tib-Fib	RT	LT
☐ Ankle	RT	LT
☐ Calcaneus	RT	LT
☐ Foot	RT	LT
☐ Toe	RT	LT
☐ Patella	RT	LT

GI/GU TRACT
- ☐ Esophagus
- ☐ UGI
- ☐ Colon (Barium Enema)
- ☐ Small Bowel Series
- ☐ IVP
- ☐ Modified Barium Swallow (with Speech Pathologist)

(See other side for Prep)

☐ ULTRASOUND *(See other side for prep)*

SPECIFIC EXAM(S) REQUESTED

OBSTETRIC ULTRASOUND

LMP: _____
- ☐ Dating _____
- ☐ IPS (11 - 14 weeks)
- ☐ Routine (18 - 20 weeks)
- ☐ Other (please specify) _____
- ☐ Biophysical profile
- ☐ BREAST ☐ RT ☐ LT (LMH)
- ☐ SMALL PARTS
  - ☐ Thyroid
  - ☐ Neck
  - ☐ Scrotum

☐ MSK *CIRCLE*
- ☐ KNEE RT LT
- ☐ SHOULDER RT LT
- ☐ OTHER _____

☐ VASCULAR *CIRCLE*
- ☐ Venous Doppler RT LT Arm Leg _____
- ☐ Arterial Doppler RT LT Arm Leg _____
- ☐ Carotid Doppler RT LT _____

- ☐ PELVIS (Transvag if needed) Bladder, Uterus, Ovaries, Prostate
- ☐ ABDOMEN: Complete or
- ☐ ABDOMEN: Limited – Specify _____
- ☐ APPENDIX
- ☐ KIDNEYS & BLADDER

☐ **OTHER ULTRASOUND EXAM DETAILS**

WSIB ☐ **Yes** ☐ **No** **DATE OF INJURY** **CLAIM #**

PATIENT HISTORY:

TECH SIGNATURE AND COMMENTS

Dr. Signature *(Mandatory)* DATE ORDERED: _____ Additional Copies to:

Dec. 2011