PLEASE NOTE:

- Children whose parents are having an examination WILL NOT be allowed into the exam room **PLEASE MAKE THE NECESSARY BABYSITTING ARRANGEMENT**S.
- Please arrive 15 minutes prior to your scheduled appointment time for registration and changing if required.
- If you cannot keep your appointment, please telephone us immediately.

****PLEASE REMEMBER WE ARE A FRAGRANCE-FREE FACILITY****

PREPARATIONS AND INSTRUCTIONS:

☐ **UPPER GI SERIES**

1. Nothing to eat or drink after midnight.
2. For small bowel exams ONLY, you may be required to be in the Diagnostic Imaging Department for up to four hours.

☐ **Bone Mineral Density Preparation:**

1. Please discontinue taking calcium supplements, Antacids (Rolaids or Tums) or Multi-Vitamins 24 hrs. prior to your appointment time. **If a supplement has been taken your test will be rescheduled.**
2. Be prepared to be changed into a hospital gown for an optimal exam.

Patient Name (REQUIRED)	
D.O.B	
Address	
Phone #	HC #

HEADWATERS Health Care Centre

GENERAL RADIOLOGY REQUISITION

100 Rolling Hills Drive, Orangeville ON L9W 4X9

Phone: 519-941-2410 Fax: 519-941-7726

Mon-Fri: 7:00am – 7:45pm

Sat-Sun: 8:00am – 12:00pm & 12:45 – 3:45pm

Clear Form

Without this SIGNED requisition your exam CANNOT be performed. Please bring your Ontario Health Card. Please arrive 15 minutes prior to exam time. Late patients may be required to reschedule exams.
INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN A DELAY OF BOOKING

X-RAY (NO APPOINTMENT NEEDED)

SPINE & PELVIS

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar (L/S) Spine
- ☐ Sacrum/Coccyx
- ☐ S.I. Joints
- ☐ Pelvis
- ☐ Scoliosis series

HEAD & NECK

- ☐ Neck for Soft Tissues
- ☐ Skull
- ☐ Orbits
- ☐ Facial Bones
- ☐ Nose
- ☐ Mandible
- ☐ T.M. Joints

CHEST & ABDOMEN

- ☐ Chest PA & LAT
- ☐ Ribs ☐ R ☐ L
- ☐ Sternoclavicular Joints.
- ☐ Sternum
- ☐ Abdomen: Supine
- ☐ Abdomen: Upright & Supine

UPPER EXTREMITY

☐ Clavicle	☐ L	☐ R	☐ Forearm	☐ L	☐ R
☐ A.C. Joints			☐ Wrist	☐ L	☐ R
☐ Shoulder	☐ L	☐ R	☐ Scaphoid	☐ L	☐ R
☐ Scapula	☐ L	☐ R	☐ Hand	☐ L	☐ R
☐ Humerus	☐ L	☐ R	☐ Digit 1 2 3 4 5	☐ L	☐ R
☐ Elbow	☐ L	☐ R	☐ Bone Age		

LOWER EXTREMITIES

☐ Hip	☐ L	☐ R	☐ Foot	☐ L	☐ R
☐ Femur	☐ L	☐ R	☐ Toe 1 2 3 4 5	☐ L	☐ R
☐ Knee	☐ L	☐ R	☐ Calcaneus	☐ L	☐ R
☐ Tib & Fib	☐ L	☐ R	☐ Leg Length		
☐ Ankle	☐ L	☐ R			

☐ Other X-ray:

GASTRICS (BY APPOINTMENT ONLY)

☐ Upper GI Series ☐ Modified Barium Swallow – (with speech language pathologist)

BONE MINERAL DENSITY (BY APPOINTMENT ONLY)

☐ Baseline (one per Lifetime)
☐ High risk (one every 12 months)
☐ First Screening recheck (36 months after normal base line)
☐ Screening rechecks other than first (one every 60 months)

Must indicate reason **(Required)**:

Previous Bone Mineral Density Scan **(Required)**:

☐ No ☐ Yes - Date of last scan:

CLINICAL INFORMATION (REQUIRED)

☐ Urgent Report Needed ☐ Follow up in ER

Ordering Physician: (Print Name) _____

Ordering Physician Signature: _____

Date: _____ CC: _____

Office Phone Number: (Required) _____

Please refer to the preparation instructions sheet for the appropriate exam