

Radiography Requisition

General Radiography, Gastrics, Special Procedures (e.g. arthrogram)

Please fax to (905) 830-5966

Please DO NOT cover Referring Physician information

 Referring Physician: (print first, last): _____
 CPSO# _____ Signature: _____
 Address: _____
 Office Phone: _____ Office Fax: _____
 Date: dd / mm / yy

Patient Name: (print first, last)		Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Address:		Patient Weight: _____ kg	
City	Street Number + Name	Province	Apartment
		Postal Code	Cell: ()
Health Card Number:		Version Code:	Home: ()
Other Insurance:		Email:	
Patient DOES NOT consent to be contacted via: <input type="checkbox"/> Text <input type="checkbox"/> Email (for patient privacy information see the next page)			
Hoyer Lift Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient arriving by Ambulance Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Clinical Question and Relevant Clinical Information:
(must be provided and please be specific)
EXAM REQUIRED (check all that apply)

Chest <input type="checkbox"/> Chest PA & LAT <input type="checkbox"/> L <input type="checkbox"/> R Ribs and Chest PA <input type="checkbox"/> Sternoclavicular Joints <input type="checkbox"/> Sternum	Upper Extremities <table style="width: 100%;"> <tr> <th style="text-align: left;">L</th> <th style="text-align: left;">R</th> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Shoulder</td> </tr> <tr> <td><input type="checkbox"/> Clavicle</td> <td><input type="checkbox"/> Clavicle</td> </tr> <tr> <td><input type="checkbox"/> A.C. Joint</td> <td><input type="checkbox"/> A.C. Joint</td> </tr> <tr> <td><input type="checkbox"/> Scapula</td> <td><input type="checkbox"/> Scapula</td> </tr> <tr> <td><input type="checkbox"/> Humerus</td> <td><input type="checkbox"/> Humerus</td> </tr> <tr> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Elbow</td> </tr> <tr> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Forearm</td> </tr> <tr> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Wrist</td> </tr> <tr> <td><input type="checkbox"/> Scaphoid</td> <td><input type="checkbox"/> Scaphoid</td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Hand</td> </tr> <tr> <td><input type="checkbox"/> Fingers</td> <td><input type="checkbox"/> Fingers</td> </tr> </table> No. <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	L	R	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Clavicle	<input type="checkbox"/> Clavicle	<input type="checkbox"/> A.C. Joint	<input type="checkbox"/> A.C. Joint	<input type="checkbox"/> Scapula	<input type="checkbox"/> Scapula	<input type="checkbox"/> Humerus	<input type="checkbox"/> Humerus	<input type="checkbox"/> Elbow	<input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm	<input type="checkbox"/> Forearm	<input type="checkbox"/> Wrist	<input type="checkbox"/> Wrist	<input type="checkbox"/> Scaphoid	<input type="checkbox"/> Scaphoid	<input type="checkbox"/> Hand	<input type="checkbox"/> Hand	<input type="checkbox"/> Fingers	<input type="checkbox"/> Fingers	Lower Extremities <table style="width: 100%;"> <tr> <th style="text-align: left;">L</th> <th style="text-align: left;">R</th> </tr> <tr> <td><input type="checkbox"/> ROSA pre-op templating*</td> <td><input type="checkbox"/> ROSA pre-op templating*</td> </tr> <tr> <td colspan="2" style="text-align: center;"><small>Please include signed patient consent form</small></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Femur</td> <td><input type="checkbox"/> Femur</td> </tr> <tr> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Tibia & Fibula</td> <td><input type="checkbox"/> Tibia & Fibula</td> </tr> <tr> <td><input type="checkbox"/> Ankle</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/> Foot</td> </tr> <tr> <td><input type="checkbox"/> Calcaneus</td> <td><input type="checkbox"/> Calcaneus</td> </tr> <tr> <td><input type="checkbox"/> Toes</td> <td><input type="checkbox"/> Toes</td> </tr> </table> No. <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="checkbox"/> Leg Length/3 FT Standing XR	L	R	<input type="checkbox"/> ROSA pre-op templating*	<input type="checkbox"/> ROSA pre-op templating*	<small>Please include signed patient consent form</small>		<input type="checkbox"/> Hip	<input type="checkbox"/> Hip	<input type="checkbox"/> Femur	<input type="checkbox"/> Femur	<input type="checkbox"/> Knee	<input type="checkbox"/> Knee	<input type="checkbox"/> Tibia & Fibula	<input type="checkbox"/> Tibia & Fibula	<input type="checkbox"/> Ankle	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Foot	<input type="checkbox"/> Calcaneus	<input type="checkbox"/> Calcaneus	<input type="checkbox"/> Toes	<input type="checkbox"/> Toes	Gastric Procedures <input type="checkbox"/> Barium Swallow* <input type="checkbox"/> Upper GI* <input type="checkbox"/> Small Bowel Follow Through* <input type="checkbox"/> Barium Enema* <input type="checkbox"/> Gastrografin Enema* <input type="checkbox"/> VFSS*
L	R																																																
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Shoulder																																																
<input type="checkbox"/> Clavicle	<input type="checkbox"/> Clavicle																																																
<input type="checkbox"/> A.C. Joint	<input type="checkbox"/> A.C. Joint																																																
<input type="checkbox"/> Scapula	<input type="checkbox"/> Scapula																																																
<input type="checkbox"/> Humerus	<input type="checkbox"/> Humerus																																																
<input type="checkbox"/> Elbow	<input type="checkbox"/> Elbow																																																
<input type="checkbox"/> Forearm	<input type="checkbox"/> Forearm																																																
<input type="checkbox"/> Wrist	<input type="checkbox"/> Wrist																																																
<input type="checkbox"/> Scaphoid	<input type="checkbox"/> Scaphoid																																																
<input type="checkbox"/> Hand	<input type="checkbox"/> Hand																																																
<input type="checkbox"/> Fingers	<input type="checkbox"/> Fingers																																																
L	R																																																
<input type="checkbox"/> ROSA pre-op templating*	<input type="checkbox"/> ROSA pre-op templating*																																																
<small>Please include signed patient consent form</small>																																																	
<input type="checkbox"/> Hip	<input type="checkbox"/> Hip																																																
<input type="checkbox"/> Femur	<input type="checkbox"/> Femur																																																
<input type="checkbox"/> Knee	<input type="checkbox"/> Knee																																																
<input type="checkbox"/> Tibia & Fibula	<input type="checkbox"/> Tibia & Fibula																																																
<input type="checkbox"/> Ankle	<input type="checkbox"/> Ankle																																																
<input type="checkbox"/> Foot	<input type="checkbox"/> Foot																																																
<input type="checkbox"/> Calcaneus	<input type="checkbox"/> Calcaneus																																																
<input type="checkbox"/> Toes	<input type="checkbox"/> Toes																																																
Abdomen <input type="checkbox"/> KUB (1 View) <input type="checkbox"/> Acute (2 View)	Spine & Pelvis <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Cervical</td> <td><input type="checkbox"/> Pelvis</td> </tr> <tr> <td><input type="checkbox"/> Thoracic</td> <td><input type="checkbox"/> SI Joints</td> </tr> <tr> <td><input type="checkbox"/> Lumbosacral</td> <td><input type="checkbox"/> Scoliosis</td> </tr> <tr> <td><input type="checkbox"/> Sacrum & Coccyx</td> <td></td> </tr> </table>	<input type="checkbox"/> Cervical	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Thoracic	<input type="checkbox"/> SI Joints	<input type="checkbox"/> Lumbosacral	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Sacrum & Coccyx		<div style="border: 2px solid black; padding: 5px;"> *ALL EXAMS MARKED WITH AN ASTERISK REQUIRE AN APPOINTMENT TO BE SCHEDULED Please fax requisition to: 905-830-5966 </div>	Special Procedures <input type="checkbox"/> Voiding Cystogram* <input type="checkbox"/> Cystogram Indwelling Catheter* <input type="checkbox"/> Sinogram* <input type="checkbox"/> Lumbar Puncture* <input type="checkbox"/> Joint Aspiration* <input type="checkbox"/> Arthrogram/Injection* Specify joint/body part: <input type="checkbox"/> Skeletal Survey*																																						
<input type="checkbox"/> Cervical	<input type="checkbox"/> Pelvis																																																
<input type="checkbox"/> Thoracic	<input type="checkbox"/> SI Joints																																																
<input type="checkbox"/> Lumbosacral	<input type="checkbox"/> Scoliosis																																																
<input type="checkbox"/> Sacrum & Coccyx																																																	

Other Request (not listed above)
 Specify:

**PATIENT PREPARATIONS AND INSTRUCTIONS ON REVERSE SIDE.
 PHYSICIANS PLEASE CHECK APPROPRIATE BOX INDICATING PATIENT PREPARATION INSTRUCTIONS**


Diagnostic Imaging

Radiography Patient Preparation and Information

Physicians please check appropriate box () indicating patient preparation instructions.

Medications can be taken prior to your test with a **small** amount of water.

Patients with diabetes: Please inform patient scheduling at 905-895-4521, ext. 2665 that you have diabetes when booking your appointment. If you use insulin, you must consult your doctor about adjusting your dose.

Barium Swallow / Esophagus, Stomach, Duodenum (ESD) / Upper GI / Small Bowel (SBFT):

Age	Preparation
0-2	Nothing to eat or drink 4 hours before exam
2+	Nothing to eat or drink after midnight

Please note the exam for a Small Bowel (SBFT) may take up to 3 hours to complete.

Adult Colon / Barium Enema:

Obtain CITROMAG and DULCOLAX tablets and DULCOLAX suppository from your pharmacist. Start the preparation the day before your test. Times shown are approximate.

- Noon - Eat a low residue lunch (eg. clear soup, chicken sandwich without butter or lettuce, jello, skim milk).
- 2 p.m. - Drink a full glass of clear fluid (eg. water, pop, clear fruit juice, beer, tea or coffee with sugar but without cream).
- 4 p.m. - Drink a full glass of clear fluid.
- 6 p.m. - Eat a low residue dinner (same as lunch).
- 7 p.m. - Drink a full glass of clear fluid.
- 8 p.m. - Drink one bottle of cold CITROMAG.

Drink liberal amounts of clear fluids after each bowel movement. At bedtime, take one DULCOLAX tablet.

Morning of Test - Drink moderate amounts of clear fluids. **DO NOT EAT.** Upon waking, insert one DULCOLAX suppository in rectum and retain it until a forced evacuation occurs.

Paediatric Colon / Barium Enema:

There is no preparation for children 10 years and under.



PRIVACY POLICY DOCUMENTATION
via QR code link below or via Southlake's
privacy office webpage