GENERAL REQUISITION FORM

TO REQUEST AN APPOINTMENT SCAN BELOW

FOR APPOINTMENT BOOKING, PLEASE CALL 519-256-4914 OR FAX: 519-256-3221

PLEASE PROVIDE 24 HOURS ADVANCE NOTICE IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT

PLEASE ARRIVE 10 MINUTES EARLY FOR YOUR APPOINTMENT WITH YOUR HEALTH CARD & THIS FORM

FOR PREPARATIONS VISIT WWW.CLEARIMAGING.CA FOR MORE INFORMATION

PATIENT INFORMATION

LAST NAME: ____________________

FIRST NAME: ____________________

PHONE NO.: ____________________

ADDRESS: ____________________

HEALTH CARD NO.: ____________________ VERSION CODE ☐☐

DATE OF BIRTH: MM ____ DD ____ YYYY ____

PROVIDER INFORMATION

PROVIDER NAME (PRINT): ____________________

APPOINTMENT DATE: ____________________

PROVIDER SIGNATURE: ____________________

APPOINTMENT TIME: ____________ ☐ STAT

CC: ____________________ BILLING NO.: ____________________

CLINICAL HX: ____________________

____

NO APPOINTMENT REQUIRED

X-RAY

CHEST
- ☐ CHEST PA & LAT
- ☐ STERNUM
- ☐ SC JOINTS
- ☐ RIBS ☐ R ☐ L
- ☐ IMMIGRATION VISA

SPINE & PELVIS
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ SACRUM & COCCYX
- ☐ PELVIS
- ☐ PELVIS & HIPS ☐ R ☐ L
- ☐ SI JOINTS
- ☐ SCOLIOSIS SERIES

UPPER EXTREMITIES
- ☐ R ☐ L SHOULDER
- ☐ R ☐ L CLAVICLE
- ☐ R ☐ L AC JOINTS
- ☐ R ☐ L SCAPULA
- ☐ R ☐ L HUMERUS
- ☐ R ☐ L ELBOW
- ☐ R ☐ L FOREARM
- ☐ R ☐ L WRIST }
- ☐ R ☐ L HAND }
- ☐ R ☐ L DIGITS
- ☐ R ☐ L WRIST & SCAPHOID

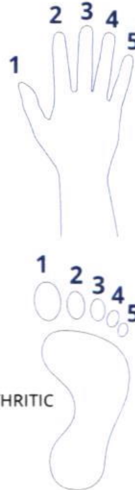
LOWER EXTREMITIES
- ☐ R ☐ L HIP
- ☐ R ☐ L FEMUR
- ☐ R ☐ L KNEE
- ☐ R ☐ L KNEE DEGENERATIVE/ARTHRITIC (INCL. Standing Bilateral)
- ☐ R ☐ L TIBIA & FIBULA
- ☐ R ☐ L ANKLE
- ☐ R ☐ L FOOT
- ☐ R ☐ L CALCANEUS
- ☐ R ☐ L TOES

☐ LEG LENGTHS DONE ONLY AT OUR OUELLETTE LOCATION

ABDOMEN
- ☐ KUB/FLAT PLATE
- ☐ ACUTE (3 VIEWS)

SKELETAL SURVEY
- ☐ BONE AGE
- ☐ METASTATIC

HEAD & NECK
- ☐ SKULL
- ☐ FACIAL BONES
- ☐ NASAL BONES
- ☐ MANDIBLE
- ☐ TM JOINTS
- ☐ SOFT TISSUE NECK
- ☐ ORBITS (MRI / FB)
- ☐ ORBITS (TRAUMA)



APPOINTMENT REQUIRED FOR ALL EXAMS BELOW

ULTRASOUND

GENERAL
- ☐ ABDOMEN + PELVIS COMPLETE (INCL. Transvaginal US for females)
  - ☐ NO TRANSVAGINAL US
- ☐ ABDOMEN COMPLETE (INCL. limited bladder & lower quadrants - not reproductive organs)
  - ☐ PORTAL HYPERTENSION/CIRRHOSIS
  - ☐ CIRRHOSIS/CHRONIC HEPATITIS SCREENING (q6 mo)
- ☐ ABDOMEN ONLY
- ☐ KIDNEYS & BLADDER*
- ☐ R/O APPENDICITIS (INCL. adjacent DDx structures)
- ☐ R/O PYLORIC STENOSIS (0-6 months)
- ☐ OTHER ____________________

PELVIS
- ☐ FEMALE PELVIS (INCL. Transvaginal)
  - ☐ NO TV
- ☐ MALE PELVIS (excludes transrectal)
- ☐ TRANSRECTAL PROSTATE (INCL. Bladder)
- ☐ BLADDER
  - ☐ INCLUDE POSTVOID RESIDUAL/PVR

SMALL PARTS
- ☐ THYROID (only)
- ☐ COMPLETE NECK (INCL. THYROID & SALIVARY GLANDS)
  LOCATION ____________________
- ☐ LUMP / LYMPH NODE(S) / SOFT TISSUE
  LOCATION ____________________
- ☐ GROIN FOR HERNIA (INGUINAL/FEMORAL) R ☐ L ☐ B ☐
- ☐ SCROTUM (TESTICULAR)
- ☐ ABDOMINAL WALL

* BASELINE ABDOMINAL ULTRASOUND MAY BE PERFORMED.

MUSCULOSKELETAL

☐ INCLUDE RELEVANT X-RAYS

	R	L	B
☐ ROTATOR CUFF	☐	☐	☐
☐ ELBOW	☐	☐	☐
☐ WRIST	☐	☐	☐
☐ HAND	☐	☐	☐
☐ HIP	☐	☐	☐
☐ KNEE	☐	☐	☐
☐ ANKLE	☐	☐	☐
☐ FOOT	☐	☐	☐

☐ OTHER ____________________

VASCULAR
- ☐ CAROTID ARTERIES
  - ☐ CIMT
- ☐ AORTA / ILIACS (AAA SCREEN)
- ☐ LOWER EXTREMITY

	R	L	B
☐ ARTERIAL	☐	☐	☐
☐ VENOUS R/O DVT	☐	☐	☐
☐ VENOUS INSUFFICIENCY	☐	☐	☐

☐ INCLUDE VENOUS CONSULTATION

☐ UPPER EXTREMITY

	R	L	B
ARTERIAL	☐	☐	☐
☐ VENOUS R/O DVT	☐	☐	☐

OBSTETRICAL

LMP: ____________

- ☐ 1ST TRIMESTER (<11 WEEKS)
- ☐ OB SERIES (NT 11-14WK + ANATOMY 18-20WK)
- ☐ EFTS / NT (11-14 WEEKS)
- ☐ ANATOMY SCAN (18-20 WEEKS)
- ☐ 2ND / 3RD TRIMESTER (NON ROUTINE)

INDICATION ____________

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BONE MINERAL DENSITY

☐ FIRST ☐ ROUTINE ☐ HIGH RISK

DATE OF LAST BMD: ____________

DIGITAL BREAST IMAGING

- ☐ MAMMOGRAPHY - ROUTINE
- ☐ MAMMOGRAPHY - DIAGNOSTIC *
- ☐ MAMMOGRAPHY - OBSP
- ☐ MALE BREAST - BILATERAL ULTRASOUND

☐ BREAST ULTRASOUND R ☐ L ☐ B ☐

* REGION OF INTEREST

ECHOCARDIOGRAPHY

(Appointment Required)

Accredited by CorHealth Ontario

☐ 2D ECHOCARDIOGRAM

INDICATION / HISTORY (REQUIRED) ____________________

☐ HOLTER MONITOR ☐ 3- DAYS

NUCLEAR MEDICINE

- ☐ NUCLEAR CARDIAC STRESS TEST
  - ☐ PERSANTINE
- ☐ HIDA
- ☐ BONE SCAN ____________________
- ☐ MYOCARDIAL WALL MOTION (MUGA) WITH EJECTION FRACTION

VEIN CLINIC

☐ ASSESSMENT/CONSULTATION

REASON FOR REFERRAL: ____________________

PLEASE ATTACH PRESENT AND PAST MEDICAL HISTORY, LIST OF CURRENT MEDICATIONS, PHYSICAL FINDINGS AND RELEVANT TEST RESULTS AND REPORTS

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PLEASE NOTE THAT ALL OUR FACILITIES ARE SCENT FREE.

This requisition form can be submitted to any licensed healthcare facility, including hospitals and IHF's, such as those listed here: www.health.gov.on.ca

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