Diagnostic Imaging General Radiography

William Osler Health System

****Bring this form with you at time of exam**** **No appointment required unless indicated below**

Patient Information

Name:_____ Date of Birth*(DD/MM/YYYY)*:_____
Health Card No:_____ Version Code:_____
Address:_____ City:_____ Prov.:_____ Postal Code:_____
Tel:_____ Email:_____

To **request DI exam for discharged ED / UCC patient**, select time frame* for DI exam, and send patient with this requisition to the DI remote / EDDI desk to book DI exam. **Do not fax this requisition.** ◯Less than 24h ◯Less than 48h ◯Less than 10 days ◯Less than 1 month

Examination Requested

Head & Neck
- ☐ Skull
- ☐ Orbits
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Mandible
- ☐ Soft Tissue Neck
- ☐ T.M. Joints

Chest
- ☐ Chest PA & Lat.
- ☐ Lordotic
- ☐ Ribs: ☐ Left ☐ Right
- ☐ Sternum
- ☐ S.C. Joints

Upper Extremity

Left	Right	
☐	☐	Shoulder
☐	☐	Scapula
☐	☐	Clavicle
☐	☐	A.C Joint
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Finger: 1, 2, 3 ,4, 5

☐ Bone Age Hand + wrist

Lower Extremity

Left	Right	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tibia-Fibula
☐	☐	Ankle
☐	☐	Calcaneus
☐	☐	Foot
☐	☐	Toe: 1, 2, 3, 4, 5
☐	☐	3 Ft. Standing Legs

Abdomen
- ☐ KUB
- ☐ Acute Abdomen Series

Spine & Pelvis
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum/Coccyx
- ☐ S. I. Joints
- ☐ Scoliosis (1 view) (2 views)
- ☐ Pelvis

Surveys
- ☐ Metastatic
- ☐ Arthritic
- ☐ Skeletal
- ☐ **Othe**r:_____

Minor Procedures
(Mandatory) Is patient on any anticoagulants/antiplatelets? ◯Yes ◯No
If Yes, specify name(s):_____
Medically safe to stop anticoagulants/antiplatelets prior to procedure: ◯Yes ◯No

(Requires appointment Fax to 905-494-6618) Next available appointment ◯ Site Preference: BCH ◯ EGH ◯
- ☐ Pre-MRI Arthrogram (Specify body part):_____ ☐ Left ☐ Right
- ☐ Lumbar Puncture
- ☐ Sinogram _____
- ☐ Steroid Injection (Specify body part):_____ ☐ Left ☐ Right
  Amount:_____
- ☐ Other:_____

Contrast allergy: ◯Yes ◯No

GI Tract (Requires appointment Fax to 905-494-6618) Next available appointment ◯ Site Preference: ◯ BCH ◯EGH
- ☐ Esophagus
- ☐ Upper GI Series
- ☐ Small Bowel Follow Through
- ☐ Barium Enema
- ☐ Voiding Cystogram
- ☐ Gastrografin Enema
- ☐ Other:_____

Clinical History (Mandatory):

Provider Name (Print): _____ CPSO/OHIP Billing #: _____

Telephone: _____ Fax: _____ Copies to (Provider Name): _____

Provider Signature: _____Date: _____

*Booking date is dependent on appointment availability and radiologist supervised clinical triaging based on provided clinical history
NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING
Form # 8100-060 – (Rev. 28_02_2024)