REQUEST FOR CONSULTATION

Oshawa Clinic Group

Whitby Imaging, Whitby Health Centre
198 Des Newman Blvd, Whitby, ON L1P 0P9
Ph. 905-721-3588 Fax 905-721-4168

Courtice Imaging Courtice Health Centre
1450 Highway #2, Courtice, ON, L1C 3C3
Ph. 905-721-4932 Fax 905-721-3524

Taunton Imaging Centre Taunton Health Centre
1290 Keith Ross Crt., Oshawa, ON, L1H 7K4
Ph. 905-721-7702 Fax 905-721-7704

***** Please note there will be a $50 charge for missed appointments *****

Date of Referral:

PLEASE BRING HEALTH CARD & THIS REQUISITION

Diagnostic Imaging

Patient label here

X-Ray

ABDOMEN
- ☐ KUB
- ☐ Acute Abdomen

HEAD
- ☐ Skull
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Mandible
- ☐ T.M. Joints
- ☐ Adenoids/S.T. Neck
- ☐ Orbits MRI

SPINE & PELVIS
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbo-sacral
- ☐ Sacrum & Coccyx
- ☐ S.I. Joints
- ☐ Pelvis
- ☐ Rt. ☐ Lt. Hip
- ☐ Scoliosis Screen (THC)

CHEST
- ☐ PA & Lateral ☐ Apical
- ☐ Rt. ☐ Lt. RIBS & PA Chest
- ☐ Sternum

UPPER EXTREMITIES
- ☐ AC Joints
- ☐ Rt. ☐ Lt. Shoulder
- ☐ Rt. ☐ Lt. Clavicle
- ☐ Rt. ☐ Lt. Scapula
- ☐ Rt. ☐ Lt. Humerus
- ☐ Rt. ☐ Lt. Elbow
- ☐ Rt. ☐ Lt. Forearm
- ☐ Rt. ☐ Lt. Wrist
- ☐ Rt. ☐ Lt. Scaphoid
- ☐ Rt. ☐ Lt. Hand
- ☐ Rt. ☐ Lt. Digits

LOWER EXTREMITIES
- ☐ Rt. ☐ Lt. Femur
- ☐ Rt. ☐ Lt. Knee
- ☐ Rt. ☐ Lt. Tibia Fibula
- ☐ Rt. ☐ Lt. Ankle
- ☐ Rt. ☐ Lt. Heel
- ☐ Rt. ☐ Lt. Foot
- ☐ Rt. ☐ Lt. Toes
- ☐ **OTHER X-Rays (see comments)**

- ☐ VERBAL*
- ☐ URGENT
- ☐ TAKE BACK*
- ☐ LEAVE

Bone Mineral Density (by appointment only)

- ☐ Baseline 1st BMD
- ☐ Bone Density high risk
- ☐ Bone Density 5 yr follow-up

(Taunton site only)

APPOINTMENT

DATE: **TIME:**

Ultrasound (by appointment only)

VASCULAR
- ☐ Duplex Carotid Doppler
- ☐ Aorta (AAA)
- ☐ Art. Dopler Upper Ext.
- ☐ Art. Doppler Lower Ext.
- ☐ Rt. ☐ Lt. Venous Doppler Upper Ext
- ☐ Rt. ☐ Lt. Venous Doppler Lower Ext

MUSCULOSKELETAL

Please provide recent x-ray report (<3 mo.)
- ☐ Rt. ☐ Lt. Shoulder
- ☐ Rt. ☐ Lt. Knee
- ☐ Other (see comments)

OBSTETRICS
- ☐ Dating (under 18 wks) LMP:
- ☐ Routine (over 18 wks)
- ☐ Nuchal Translucecy (NT)
- ☐ OB High Risk ☐ Complete ☐ Limited

SMALL PARTS
- ☐ Thyroid and/or neck
- ☐ Eyes
- ☐ Testes

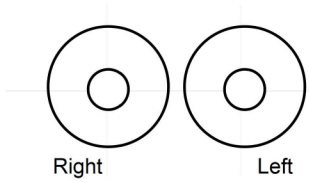
GENERAL
- ☐ Hernia Ass: ☐ Inguinal/Femoral ☐ Abd Wall ☐ Umbilical
- ☐ Abdomen Complete ☐ Kidney & Pelvis only
- ☐ Pelvis Male
- ☐ Pelvis Female **For urinary bladder, mass, bowel and lower abd pain
- ☐ Endovaginal **provides significantly higher sensitivity** for uterus, endometrium and ovaries
- ☐ **OTHER U/S (see comments)**

By appointment only

No Underarm Deodorant on the day of the exam!

MAMMOGRAPHY
- ☐ Bilateral
- ☐ Right ☐ Left

BREAST ULTRASOUND
- ☐ Bilateral
- ☐ Right ☐ Left



Signed Electronically:

Referring Physician:

Clinical Comments:

Copy to:

TECHNOLOGIST ONLY:
- ☐ Lead used
- ☐ Mask
- ☐ Face shield
- ☐ Patient NOT Pregnant

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx.