Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital
Partnering to keep healthcare close to home.

GENERAL RADIOLOGY REQUISITION

☐ Alexandra Hospital Ingersoll (AHI)
AHI Scheduling/Bookings Contact:
Phone: 519-485-9611 Fax: 519-485-9601

☐ Tillsonburg District Memorial Hospital (TDMH)
TDMH Scheduling/Bookings Contact:
Phone: 519-842-6335 Fax: 519-842-4299

Referring Physician or Other Authorized Health Care Provider

Name (Please Print): _____

Phone:_____Fax:_____

Provider Billing #: _____

Provider Signature: _____

Copy to: _____

Patient Information:

Name (Last, First): _____

Date of Birth (DOB):_____ ☐ Male ☐ Female
YYYY MM DD

Personal Identification Number (PIN): _____

Address:_____

Phone Number (Home):_____

(Other):_____

Health Card Number:_____Version Code:_____

☐ Workplace Safety & Insurance Board (WSIB)? (Please include approval for specific exam)

Claim #: _____

Date of injury (YYYY/MM/DD): _____

☐ 3rd Party or Insurance (Company or Self-pay): _____

Does this patient have special considerations or movement restrictions? Please specify: _____

Nursing Home, Hoyer Lift, Other _____

Examination Requested:

HEAD AND NECK	SPINE	CHEST	ABDOMEN	Gastro Intestinal (GI) TRACT* (TDMH only)
☐ Orbits (for Magnetic resonance imaging) (MRI) ☐ Skull ☐ Soft Tissue Neck ☐ Facial bones ☐ Nasal Bones ☐ Mandible Temporomandibular (TM) Joints	☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacrum and Coccyx ☐ Sacroiliac Joints ☐ Scoliosis (TDMH only) (complete spine 1 view)	☐ Chest ☐ Sternum Ribs ☐ Right ☐ Left	☐ Kidney, Ureter, Bladder (KUB) (1 view) ☐ Acute Abdomen Series (3 views) ☐ 1 View Abdomen (Constipation)	*Preparation required ☐ Barium Swallow ☐ Upper GI ☐ Small Bowel (SBFT) (will be protocoled by Radiologist)

UPPER EXTREMITIES	LOWER EXTREMITIES	CLINICAL INFORMATION OR DIAGNOSIS SUSPECTED
☐ Acromioclavicular Joints Right Left ☐ ☐ Clavicle ☐ ☐ Shoulder ☐ ☐ Scapula ☐ ☐ Humerus ☐ ☐ Elbow ☐ ☐ Forearm ☐ ☐ Wrist ☐ ☐ Scaphoid ☐ ☐ Hand ☐ ☐ Thumb (digit 1) ☐ ☐ Finger ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Hips to Ankle (Orthopaedic) (TDMH only) ☐ Pelvis ☐ Leg Length (scanogram) (TDMH only) Right Left ☐ ☐ Hip ☐ ☐ Femur ☐ ☐ Knee ☐ ☐ Tibia Fibula ☐ ☐ Ankle ☐ ☐ Calcaneus ☐ ☐ Foot ☐ ☐ Toe ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	Notes/Comments: _____ _____ _____ _____ _____ _____ **NOTE: THE X-RAY TABLE WEIGHT LIMIT IS 485 pounds**

UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RETURNED AND APPOINTMENTS WILL NOT BE BOOKED UNTIL A SIGNED AND COMPLETED REQUISITION IS RECEIVED.