St. Thomas Elgin General Hospital

For APPOINTMENTS, CALL (519) 631-2020
Ext 2322
Mon- Fri Only Between 8:00AM – 4:00PM
FAX (519) 631-8842

APPOINTMENT DATE AND TIME

PATIENT INFORMATION

Last Name_____ First Name _____

Address _____ DOB_____
(YY/MM/DD)

(H) Phone # _____(C) Phone#_____
__

Health Card #_____VC_____

WSIB ☐Yes
Date of injury_____
Claim #_____

Mobility Issues/Special Needs
Yes☐

Important: Please bring your health card. No children allowed in the exam room. Please arrange child care.

X-RAY- Walk-ins Welcome from 0700-16:30 Mon-Fri Sat 9am-4pm

HEAD & NECK
- ☐ Nasal Bones
- ☐ Facial Bones
- ☐ Soft Tissue of Neck
- ☐ Orbits for MRI
- ☐ Orbits- Routine
- ☐ Mandible
- ☐ TM Joints
- ☐ Skull

CHEST
- ☐ Chest PA & LAT
- ☐ Lordotic View
- ☐ Insp/Exp Views
- ☐ Ribs ☐ R ☐ L

SPINE & PELVIS
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar/Sacral Spine
- ☐ Sacrum & Coccyx
- ☐ S.I. Joints
- ☐ Pelvis
- ☐ Scoliosis Series

SURVEY
- ☐ Bone Age
- ☐ Skeletal Survey (requires an apt)

Abdomen
- ☐ KUB/Abdomen (1 view)
- ☐ Acute (3views)

UPPER EXTREMITIES

R	L	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	AC Joint
☐	☐	SC Joints
☐	☐	Scapula
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Finger_____

LOWER EXTREMITIES

R	L	
☐	☐	Hip
☐	☐	Hips to ankles (requires an apt)
☐	☐	Hip (washer view)
☐	☐	Femur
☐	☐	Knee
☐	☐	Knee (ortho view)
☐	☐	Patella
☐	☐	Tibia & Fibula
☐	☐	Ankle
☐	☐	Foot
☐	☐	Calcaneus
☐	☐	Toe_____

ULTRASOUND — All Tests Below Require an Appointment — BMD

GENERAL
- ☐ Abdomen
- ☐ Bilateral Kidneys
- ☐ KUB US
- ☐ Bladder Pre/Post Void
- ☐ Female Pelvis (proceed to TV if necessary)
- ☐ Pelvis-male
- ☐ Scrotal
- ☐ Thyroid
- ☐ Neck
- ☐ Groin R☐ L☐
- ☐ Inguinal hernia R☐ L☐
- ☐ Umbilical hernia
- ☐ Ventral hernia
- ☐ Soft Tissue Mass
  _____

VASCULAR
- ☐ Carotid
- ☐ Portal Vein

Venous Doppler (R/O DVT)
- ☐ R Arm ☐ L Arm
- ☐ R Leg ☐ L Leg

Leg Reflux
- ☐ R Leg ☐ L Leg

MUSCULOSKELETAL

Shoulder	☐ R	L ☐
Bicep	☐ R	L ☐
Knee	☐ R	L ☐
Achilles	☐ R	L ☐

- ☐ Other_____

OBSTETRICAL
LMP_____EDC_____
Current GA_____

Low Risk
- ☐ Dating
- ☐ Screening eFTS
- ☐ Routine

OB High Risk
- ☐ Twins
- ☐ Biophysical Profile
- ☐ Growth
- ☐ Fluid
- ☐ Presentation
- ☐ Doppler
- ☐ Cervical Length

SPECIALS
- ☐ **Biopsy**_____
- ☐ **Localization**
- ☐ **Trans Rectal US**

BMD
- ☐ Steroid use
- ☐ Osteoporosis meds

- ☐ 1st Baseline BMD
- ☐ Low Risk (2nd test-36 mnths)
- ☐ Low Risk (3rd test-60 mnths)
- ☐ High Risk (once every 12 mnths)

Please attach reports done outside of STEGH
Please bring list of medications.
Do not wear any metal in clothing

Specials
- ☐ UGI
- ☐ Modified Swallow
- ☐ SBFT
- ☐ Cystogram
- ☐ Hysterosalpingogram

REASON FOR EXAM/CLINICAL HISTORY

Ordering Provider:_____
Billing#:_____ **CPSO#** _____

Signature: _____
☐ **URGENT (Must Provide Contact #)**_____
The radiologist may alter orders if symptoms warrant a different test