

RADIOLOGY REFERRAL FORM

FAX to 519-646-6204

NOTE: Diagnostic Imaging (DI) is no longer accepting walk-in general x-ray patients. All general x-rays MUST be booked by **faxed requisition to 519-646-6204** or by **calling DI Bookings, 519-646-6000 ext. 65074**. For same-day exams, call DI Bookings, 519-646-6000 ext. 65074 **before sending the patient to DI**, to determine if request can be accommodated.

1. Patient information

Last name: _____ First Name: _____ Middle Initial: _____
Gender: M F Date of birth (YYYY/MM/DD): _____
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Alternate Phone: _____
Health card number: _____ Version Code: _____
WCB Employer: _____ S.I.N.# _____ ACCIDENT DATE: _____
(YYYY/MM/DD)

Preferred language English Other: _____ Interpreter required? No Yes

Mobility Ambulatory Wheelchair Stretcher Portable Mechanical lift required

Diabetes No Yes **Pregnant** No Unknown Yes, _____ weeks

2. Allergies: None **If patient has known latex or contrast allergy, please notify us as soon as possible at 519-646-6044**

3. Previous exams None

X-Ray **at** St. Joseph's Health Care London LHSC Other: _____
 Nuc Med **at** St. Joseph's Health Care London LHSC Other: _____
 Ultrasound **at** St. Joseph's Health Care London LHSC Other: _____

4. Exam requested: X-ray Injection Other: _____

Fluoroscopy (by appointment only): Upper GI series Barium swallow Small bowel follow through
 Modified Barium Swallow with Speech Language Pathologist

→ Site: _____ → Side: Right side Left side

Diagnosis suspected: _____

Clinical Findings and History:

5. Referring Health Care Provider

Last name: _____ First Name: _____ **Signature:** _____
Address: _____ City: _____ Postal Code: _____
Phone: _____ Fax: _____ OHIP Billing Number: _____
Copy to: _____ Fax _____

Radiology Dept. use only: Emergency Urgent Elective Research Appointment date: _____