BRANT COMMUNITY HEALTHCARE SYSTEM

X-RAY & INTERVENTIONAL RADIOLOGY REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9

BGH Ph: 519-751-5599 Fax: 519-751-5573

Willett Ph: 519-442-2251 Fax: 519-442-5172

For Office Use Only:
Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION	
Name:		Health Card / Version / DOB (D D M M Y Y Y Y) / Sex (M F U)	
OHIP Billing Number:		First Name:	Last Name:
Address		Address:	
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:		WSIB Claim #:	Secondary Insurance:
Copies to:		Patient Height:	Patient Weight:

Does Patient Require Assistance? ☐Mechanical Lift ☐ Wheelchair ☐Language Interpreter - Specify:

BGH X-Ray Hours: Monday to Friday 08:00-19:00, Weekends and Holidays 08:00-15:00
Willett X-Ray Hours Monday to Friday 09:00-20:30, Weekends 10:00-17:30 ***Exams at BGH Site Only**

Head and Neck
- ☐ Adenoids
- ☐ Facial Bones
- ☐ Mandible
- ☐ Mastoids
- ☐ Nasal Bones
- ☐ Orbits *
- ☐ Skull
- ☐ Soft tissue of Neck
- ☐ TMJ's

Chest
- ☐ Chest (PA/LAT)
- ☐ Ribs
- ☐ Sternum
- ☐ Sternoclavicular Joints

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

Upper Extremities
- ☐L ☐R A.C. Joints
- ☐L ☐R Clavicle
- ☐L ☐R Elbow
- ☐L ☐R Finger ☐1 ☐2 ☐3 ☐4 ☐5
- ☐L ☐R Forearm
- ☐L ☐R Hand
- ☐L ☐R Humerus
- ☐L ☐R Scaphoid
- ☐L ☐R Scapula
- ☐L ☐R Shoulder
- ☐L ☐R Wrist

Spine and Pelvis
- ☐ Cervical
- ☐ Dorsal/Thoracic
- ☐ Lumbar
- ☐ Sacrum and Coccyx
- ☐ Sacroiliac Joints
- ☐ Scoliosis *
- ☐ AP Pelvis

Lower Extremities
- ☐L ☐R Ankle
- ☐L ☐R Calcaneus
- ☐L ☐R Femur
- ☐L ☐R Foot
- ☐L ☐R Hip ~
- ☐L ☐R Knee ~
- ☐L ☐R Tibia/Fibula
- ☐L ☐R Toe ☐1 ☐2 ☐3 ☐4 ☐5
- ☐ Orthoroentgenogram (leg length)*

~ Orthopedic consult Hips and Knees at BGH only.

Gastric Studies (Appointment Required)
- ☐ Barium Enema *
- ☐ Barium Swallow *
- ☐ Small Bowel (SBFT) *
- ☐ Upper GI *

INTERVENTIONAL RADIOLOGY (APPOINTMENT REQUIRED) BGH Site Only

Is patient on blood thinners? ☐Y ☐N If yes, please specify:

- ☐ Abdominal Drain
- ☐ Chest Tube Insertion
- ☐ Cystogram - Does pt have catheter? ☐Y ☐N
- ☐ Fistulogram
- ☐ Joint Injection specify:_____
- ☐ Linogram
- ☐ Loopogram
- ☐L ☐R Nephrostogram
- ☐L ☐R Nephrostomy Tube Change
- ☐ Paracentesis
- ☐ Sialogram
- ☐ Sinogram
- ☐ Suprapubic Catheter Change
- ☐ T Tube Cholangiogram
- ☐L ☐R Thoracentesis
- ☐ Urethrogram
- ☐ Other - Please specify:

CLINICAL HISTORY: REASON FOR ORDER

Previous Surgeries:

Related Previous Imaging: ☐Yes ☐ No If yes, Where: **Please attach previous if not completed at BGH.**

Please include all relevant patient history including previous reports or consult notes as appropriate.