

BRANT COMMUNITY HEALTHCARE SYSTEM X-RAY & GASTRIC EXAM REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9 BGH Ph: 519-751-5599 Fax: 519-751-5573

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For Office Use Only:	
Appointment Date/Time:	
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REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION				
Name:		Health Card	Version I		ex	
OHIP Billing Number:		First Name:	Last Nam	D D M M Y Y Y Y M	F U	
Address		Address:				
City/Prov:	Postal Code:	City/Province:	Postal Co	de.		
City/F10V.	rostal code.	City/Frovince.	rostarco	nue.		
Phone:	Fax:	Phone Number:	Secondar	ry Phone Number:		
Signature:		WSIB Claim #:		Secondary Insurance:		
Copies to:		Patient Height:		Patient Weight:		
Does Patient Require	Assistance?	I□ Wheelchair □ Language Interpreter - S	pecify:			
		0-19:00, Weekends and Holidays		00		
	urs Monday to Friday 09	00-20:30, Weekends 10:00-17:30		*Exams at BGH Site Only		
Head and Neck		Upper Extremities		Lower Extremities		
☐ Adenoids		□L □R A.C. Joints		□L □R Ankle		
☐ Facial Bones		□ L □ R Clavicle		□L □R Calcaneus		
☐ Mandible		□L □R Elbow	_	□L □R Femur		
☐ Mastoids		□L □R Finger □1 □2 □3 □4 □		□L □R Foot		
☐ Nasal Bones		□L □R Forearm		□L □R Hip		
☐ Orbits		□L □R Hand		□L □R Knee		
Skull		□L □R Humerus		□ L □ R Tibia/Fibula		
☐ Soft tissue of Nec	k	□L □R Scaphoid		□L □R Toe □1□2□3□4□5		
☐ TMJ's		□L □R Scapula		Orthoroentgenogram (leg length)	*	
		□L □R Shoulder				
Chest		☐ L ☐ R Wrist Spine and Pelvis		Gastric Studies (Appointment Required)		
☐ Chest (PA/LAT)		☐ Cervical		Barium Enema *		
☐ Ribs		☐ Dorsal/Thoracic		☐ Barium Swallow *		
☐ Sternum		☐ Lumbar		☐ Small Bowel (SBFT) *		
☐ Sternoclavicular J	oints	☐ Sacrum and Coccyx		☐ Upper GI *		
Abdomen		☐ Sacroiliac Joints				
☐ KUB (1 view)		☐ Scoliosis *				
☐ Acute (3 views)		☐ AP Pelvis				
CLINICAL HISTOR	Y: REASON FOR ORDER					
Previous Surgerie	·s:					
Related Previous	Imaging: □Yes □ No	If yes, Where:		se attach previous if not completed at	t BGH.	