Kawartha Imaging

LINDSAY ULTRASOUND & XRAY

86 Angeline St. S. Ste. 102 Lindsay On K9V 3L5
Main Line: 705-324-0101 - Line 2: 705-324-3164 - Fax: 705-324-0105
www.lindsayultrasoundxray.ca
lindsayultrasoundxray@gmail.com

Date:

Time:

URGENT ☐

Verbal Contact # ☐

X - RAY

Abdomen
- ☐ Single View (K.U.B.)
- ☐ Acute (3 Views)

Head & Neck
- ☐ Skull
- ☐ Adenoids
- ☐ Soft Tissues of neck
- ☐ Pit. Fossa
- ☐ Mastoids
- ☐ I.A. Meat
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Orbits
- ☐ Mandible
- ☐ T.M. Joints

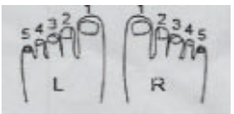
Chest
- ☐ Chest
- ☐ L ☐ R Ribs
- ☐ Sternum
- ☐ Sterno-Clavicular Joints
- ☐ Thoracic Inlet

Spine & Pelvis
- ☐ Cervical Spine
- ☐ Dorsal Spine
- ☐ Lumbar (L/S) Spine
- ☐ Sacrum-Coccyx
- ☐ S.I. Joints
- ☐ Pelvis
- ☐ Scoliosis Series

Skeletal Survey
- ☐ Metastatatic Series
- ☐ Arthritic Series
- ☐ Metabolic Series

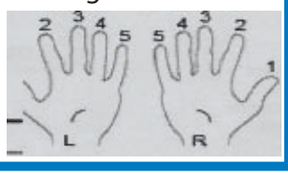
Lower Extremities
- ☐ L ☐ R Hip
- ☐ L ☐ R Femur
- ☐ L ☐ R Knee
- ☐ L ☐ R Tib & Fib
- ☐ L ☐ R Ankle
- ☐ L ☐ R Foot
- ☐ L ☐ R Calcaneus

Toes 1 2 3 4 5



Upper Extremities
- ☐ L ☐ R Shoulder
- ☐ L ☐ R Clavicle
- ☐ L ☐ R A.C. Joint
- ☐ L ☐ R Scapula
- ☐ L ☐ R Humerus
- ☐ L ☐ R Elbow
- ☐ L ☐ R Forearm
- ☐ L ☐ R Wrist
- ☐ L ☐ R Hand
- ☐ L ☐ R Scaphoid

Fingers 1 2 3 4 5



I Verify to the best of my knowledge that I am not pregnant

Clinical Information:

Physician Billing # | Fax Number:

Ultrasound

GENERAL
- ☐ Abdomen ☐ Ltd Abd
- ☐ Pelvis: Pre-Post Void (Bladder only)
- ☐ Female Pelvis ☐ Transvaginal
- ☐ Transvaginal
- ☐ Renal / Bladder only
- ☐ Male Pelvis
- ☐ Prostate-Transrectal
- ☐ L ☐ R Breast ☐ Testicular/Scrotal
- ☐ Thyroid ☐ Neck

OBSTETRICAL
- ☐ Obstetrical - Dating
- ☐ Nuchal Translucency (IPS)
- ☐ Obstetrical - High Risk
- ☐ Obstetrical - Anatomy Scan
- ☐ Obstetrical + Biophysical Profile

Musculoskeletal
- ☐ L ☐ R Hip
- ☐ L ☐ R Hamstring
- ☐ L ☐ R Knee
- ☐ L ☐ R Achilles Tendons
- ☐ L ☐ R Ankle
- ☐ L ☐ R Foot
- ☐ L ☐ R Shoulder
- ☐ L ☐ R Elbow
- ☐ L ☐ R Wrist
- ☐ L ☐ R Hand
- ☐ L ☐ R Hernia
- ☐ L ☐ R Other Muscle
- ☐ L ☐ R Other SoftTissue

Vascular
- ☐ Carotid
- ☐ Arterial Upper Ext. (bilateral only)
- ☐ Arterial Lower Ext. (bilateral only)
- ☐ ☐ Venous Upper Ext. (DVT only
- ☐ ☐ Venous Lower Ext. (DVT only)

Referred By MD _____ signature CC

OHIP Number	Patient's Last Name (please print)	Patient's First Name
Appointment Time	Patient's Birth Date DD MM YY	Sex M | F / Patient's Phone No.
Patient's Address	DATE:	

PLEASE BRING YOUR REQUISITION AND HEALTH CARD
FOR PREPARATION AND DIRECTIONS PLEASE TURN OVER

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHF's, such as those listed on the IHF program website:
http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx