WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

X-RAY REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure

Patient Information (Please Print)

Name: _____ Date of Birth (D/M/Y): _____ Sex: ❑ M ❑ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact # ( ) _____ Secondary # ( ) _____Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ❑ Y ❑ N

CLINICAL HISTORY REQUIRED

X-RAY (NO APPOINTMENT REQUIRED FOR THESE EXAMS)

CHEST
- ❑ CHEST
- ❑ STERNUM
- ❑ SC JOINTS
- ❑ RIBS ❑ R ❑ L
- ❑ LOWER ❑ UPPER

ABDOMEN
- ❑ SINGLE / KUB
- ❑ SERIES

SPINE
- ❑ CERVICAL SPINE _____
- ❑ THORACIC SPINE _____
- ❑ LUMBAR SPINE _____
- ❑ SACRUM
- ❑ COCCYX
- ❑ PELVIS
- ❑ SI JOINTS
- ❑ SCOLIOSIS SERIES

UPPER EXTREMITIES
- ❑ R ❑ L SHOULDER
- ❑ R ❑ L CLAVICLE
- ❑ R ❑ L AC JOINTS
- ❑ R ❑ L SCAPULA
- ❑ R ❑ L HUMERUS
- ❑ R ❑ L ELBOW
- ❑ R ❑ L FOREARM
- ❑ R ❑ L WRIST
- ❑ R ❑ L HAND
- ❑ R ❑ L FINGERS—SPECIFY _____

LOWER EXTREMITIES
- ❑ R ❑ L HIP
- ❑ R ❑ L FEMUR
- ❑ R ❑ L KNEE ❑ PATELLA
- ❑ R ❑ L TIBIA & FIBULA
- ❑ R ❑ L ANKLE
- ❑ R ❑ L FOOT
- ❑ R ❑ L CALCANEUS
- ❑ R ❑ L TOES - SPECIFY _____
- ❑ R ❑ L LEG LENGTHS

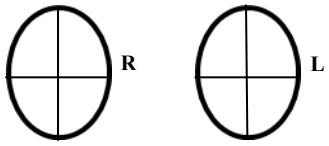
OTHER ❑ _____

HEAD
- ❑ SKULL
- ❑ SINUSES
- ❑ FACIAL BONES
- ❑ NASAL BONES
- ❑ MANDIBLE
- ❑ PANOREX
- ❑ SOFT TISSUE NECK
- ❑ ORBITS (MRI)
- ❑ ORBITS (FB)

BREAST IMAGING *DIGITAL

- ❑ MAMMOGRAM ❑ R ❑ L ❑ BILATERAL
- ❑ BREAST ULTRASOUND ❑ R ❑ L ❑ BILATERAL
- ❑ MAMMOGRAM AND BREAST ULTRASOUND ❑ R ❑ L ❑ BILATERAL
- ❑ BIOPSY BREAST ❑ R ❑ L
- ❑ DUCTOGRAM
- ❑ OBSP

REGION OF INTEREST



PREVIOUS BREAST EXAM DONE WHERE / WHEN: _____

Print Referring Physician_____ Fax Number: _____

Referring Physician Signature: _____

Physicians who require copy of report: _____

APPOINTMENT:

DATE: _____ **TIME:** _____ **CAMPUS:** _____