EMBRUN MEDICAL IMAGING
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REQUISITION

Imagerie Médicale
Medical Imaging
Embrun

REFERRING PHYSICIAN

Name: _____

CPSO #: _____ **Billing #:** _____

Address: _____

Phone #: _____

FAX #: _____

Email: _____

Signature: _____ **Date:** _____

PATIENT INFORMATION

Name: _____

Address: _____

DOB (MM/DD/YYYY): _____ **Age:** _____ **M / F**

Healthcard: _____ _____

Phone #:
(1) _____ **(Home / Cell / Work / Other)**
(2) _____ **(Home / Cell / Work / Other)**

Email: _____

ULTRASOUND (By Appointment ONLY)

GENERAL

□ Abdomen
□ AAA Screening (Aorta ONLY)
□ Abdominal Wall/Hernia
□ Kidneys/Ureter/Bladder (KUB)
□ Pelvis Female (Includes TVS Unless Contraindicated)
□ Pelvis Male (Transabdominal ONLY)
□ Post-Void Residual (Bladder ONLY)
□ Inguinal Canal/Groin/Hernia R □ L □
□ Testicles/Scrotum
□ Chest/Thorax
□ Thyroid
□ Neck R □ L □
□ Submandibular R □ L □
□ Parotid R □ L □
□ Soft Tissue/Lump (Location) R □ L □
_____
□ Other
_____

MUSCULOSKELETAL / VASCULAR

R L
□ □ Shoulder / AC Joints
□ □ Periscapular Region
□ □ Arm
□ □ Elbow
□ □ Forearm
□ □ Wrist / Hand
□ □ Hip Joint
□ □ Hamstring
□ □ Thighs
□ □ Knee
□ □ Calves
□ □ Ankle / Foot
□ □ Achilles Tendon / Plantar Fascia
□ □ Other Muscle Area (Location)
_____

□ □ Lower Limb Venous (DVT)

OBSTETRICS

Multiple Pregnancy? □ Y □ N

□ Dating (Under 16 Weeks)
□ Viability
□ Nuchal Translucency (EFTS/IPS 11w2d-13w3d)
□ Morphology/Anatomy Scan (18-20 Weeks)
□ High Risk/Complication of Pregnancy (30+ Weeks)
□ Fetal Growth
□ Biophysical Profile (BPP)
□ Cervical Length (Includes TVS Unless Contraindicated)
□ Fetal Position
□ Fetal Doppler IUGR

G ___ **P** ___ **A** ___ **E** ___

LMP: _____

EDC: _____

X-RAY

□ Chest
□ Ribs R □ L □
□ Cervical Spine
□ Thoracic Spine
□ Lumbar Spine
□ Sacrum/Coccyx
□ SI Joints
□ Pelvis (NO Hips)
□ Pelvis and Hip(s) R □ L □
□ Abdomen-Constipation
□ Abdomen-Bowel Obstruction (Includes PA Chest)

□ Kidneys/Ureter/Bladder (KUB)
□ Skull
□ Sinuses (Not Covered - OHIP)
□ Facial Bones
□ Nasal Bones
□ Orbits
□ Eye - Foreign Body (Pre-MRI)
□ Mandible

□ Other
_____

R L
□ □ Shoulder
□ □ Clavicle
□ □ Scapula
□ □ Humerus
□ □ Elbow
□ □ Forearm
□ □ Wrist
□ □ Hand
□ □ Finger
_____

R L
□ □ Femur
□ □ Calcaneus
□ □ Knee / Patella
□ □ Tibia / Fibula
□ □ Ankle
□ □ Foot (Non-Weight Bearing)
□ □ Toe
_____

BONE MINERAL DENSITY

□ Baseline
□ High Risk (1 year)
□ Routine / Follow-Up
□ 3 years □ 5 years
□ Other: _____ years

Previous Exam Date:
_____

Previous Exam Location:
_____

CLINICAL HX / RELEVANT CLINICAL FINDINGS AND/OR INFORMATION

REQUIRED

□ **STAT / Physician Emergency Off-Site Phone # (Used Only If IMMEDIATE Action Required):** _____

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: www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx.