ERIE SHORES HEALTHCARE
194 Talbot Street West, Leamington, Ontario N8H 1N9
(519) 326-2373

DIAGNOSTIC IMAGING REQUISITION
FAX # 519 326 4916

PATIENTS NAME: (please note any recent name change)

PHONE:	SEX: M or F	DATE OF BIRTH:

OHIP NUMBER: ***REQUIRED FOR BOOKING

Date:_____

REFERRED BY:_____

You must bring this form and your Health Card with you to the hospital. Register at the OUTPATIENT ENTRANCE (Fader St.) 15 minutes before your appointment. Please call if you need to change or cancel a booked appointment. **519 326-2373 ext 4000**

COPIES TO:

CLINICAL INFORMATION: Must be provided

Note: eGFR (OUTPATIENT)_____ eCrCl (INPATIENT / ER)_____
(within last 3 months) required before appointment for CT Scan will be given (except CT Spine Studies)

- ☐ ER patient - in ER
- ☐ ER patient - discharged
- ☐ Outpatient - Dr's office
  - ☐ Emergency (Radiologist consulted for US or CT)
  - ☐ Urgent (within 48hrs)
  - ☐ Somewhat urgent (within 1 week)
  - ☐ Elective
  - ☐ Other (specify)_____

EXAM REQUESTED Identify region to be scanned

APPOINTMENT Date Time

☐ Ultrasound_____ _____ _____

☐ CT Scan_____ _____ _____

☐ Mammography_____ _____ _____
Patient history of breast cancer ☐Y ☐N Implants ☐Y ☐N

☐ Special Procedure_____ _____ _____

☐ X-Ray_____
(No appointment necessary)

RADIOLOGISTS USE ONLY

IV CONTRAST
☐ With
☐ Without
ORAL CONTRAST
☐ Readi-Cat
☐ Gastrografin
☐ Water
Amt:_____

_____
Radiologist

PRIORITY
1 2 3 4

PATIENT INFORMATION

☐Y ☐N Diabetic
☐ Medication_____
☐Y ☐N History of Malignancy
(specify)_____
☐Y ☐N Epileptic
☐Y ☐N At risk to fall
☐Y ☐N Physical Disabilities
☐Y ☐N Malignant Hyperthermia
☐Y ☐N Mastectomy
☐ Other_____

Patient capable of signing own consent? ☐Y ☐N

RELEVANT PREVIOUS DIAGNOSTIC EXAMINATIONS:
Exam: Facility:

FLUORO TIME_____

PLEASE ENSURE FORM IS COMPLETE AND CLINICAL / PATIENT INFORMATION IS PROVIDED BEFORE FAXING. OHIP # IS MANDATORY