MUSKOKA ALGONQUIN HEALTHCARE

DIAGNOSTIC IMAGING – RADIOLOGY (X-Ray)

Huntsville District Memorial Hospital
100 Frank Miller Drive
Huntsville, ON P1H 1H7
T: 705-789-2311 x2242
F: 705-788-1485
Fax Requisition for Scheduling

South Muskoka Memorial Hospital
75 Ann Street
Bracebridge, ON P1L 2E4
T: 705-645-4404 x3112
F: 705-645-7567
Fax Requisition for Scheduling

Almaguin Highlands Health Centre
150 Huston Street
Burk's Falls, ON P0A 1C0
T: 705-382-2900 x224
F: 705-382-3131
Fax Requisition to 705-788-1485 for Scheduling

Effective June 2020, X-rays must be pre-booked with appointments.

Please advise your patient walk-ins are no longer possible.

Patient Demographics:

Name Last First

Address

Home Phone ( ) - Other Phone ( ) -

☐ **Do not contact patient.** Provide appointment date/time to referring provider.

DOB YYYY / MM / DD ☐ Male ☐ Female

OHIP

Isolation Precautions: ☐ Contact ☐ Droplet/Contact ☐ Airborne

Special Instructions (mobility, communication, etc): ______________________ ☐ Falls Risk ☐ Wheelchair req'd

Relevant Clinical History:

WSIB claim #:_______________

☐	Skull
☐	Facial Bones
☐	Pre MRI Orbits
☐	Nasal Bones
☐	Mandible
☐	TMJs
☐	Cervical Spine
☐	Thoracic Spine
☐	Lumbar Spine
☐	Sacrum/Coccyx
☐	SI Joints
☐	Scoliosis
☐	Leg Length **Huntsville only**

R	L	
	☐	Chest (PA/Lat)
	☐	Chest (PA)
R	**L**	
☐	☐	Ribs
☐	☐	SC Joints
	☐	Sternum
	☐	Abdomen (KUB)
	☐	Abdomen Acute
R	**L**	
☐	☐	Shoulder
☐	☐	Scapula
☐	☐	Clavicle
☐	☐	Humerus
☐	☐	AC Joints

R	L	
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Hand
	☐	Pelvis
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tibia/Fibula
☐	☐	Ankle
☐	☐	Os Calcis
☐	☐	Foot

☐ Other:

		1	2	3	4	5
Lower Digits	**R**	☐	☐	☐	☐	☐
Lower Digits	**L**	☐	☐	☐	☐	☐
Upper Digits	**R**	☐	☐	☐	☐	☐
Upper Digits	**L**	☐	☐	☐	☐	☐

Interventional Procedures

Scheduled appointment required.
Please fax requisition.

*Preparation to be given at time of booking.

**Patient must bring steroid/ injectable meds with them to appointment.

- ☐ UGI* ☐ Barium Swallow*
- ☐ Marshmallow Swallow*
- ☐ UGI and Small Bowel*
- ☐ Small Bowel*
- ☐ Colon-Air*
- ☐ Joint Injection**

Specify Joint:

- ☐ PICC Line*

Referring Provider:	Signature:	
Copies:	Date:	OHIP Billing #:

Incomplete:
☐ Patient Information ☐ Clinical History
☐ Exam Requested ☐ Signature

Refax to office ___________________________________

Office use: *VERSION: June 2020*

Cerner Codes: ______________________

Interventional appt. date/time: ___________________ ____________________