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
Open Monday to Friday
8 a.m. to 4 p.m.

South Muskoka Memorial Hospital
75 Ann Street
Bracebridge, ON P1L 2E4
T: 705-645-4404 x3112
F: 705-645-7567
Open Monday to Friday
8 a.m. to 4 p.m.

Almaguin Highlands Health Centre
150 Huston Street
Burk's Falls, ON P0A 1C0
T: 705-382-2900 x224
F: 705-382-3131
Open Mondays, Tuesdays, Thursdays
8:30 a.m. to 4:30 p.m.

Note to Patient: There may be a wait for your walk-in exam. Please bring this with you for your X-ray. Without this paper your exam cannot be completed.

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 #:_____

- ☐ Sinuses
- ☐ 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
- ☐ Other:

- ☐ 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

		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*
- ☐ 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: Nov. 2016*

Cerner Codes: _____

Interventional appt. date/time: _____ _____