SOUTH BRUCE GREY HEALTH CENTRE
CHESLEY | DURHAM | KINCARDINE | WALKERTON

# *DIAGNOSTIC IMAGING*
# *GENERAL REQUISITION*

***FOR AN APPOINTMENT PLEASE PHONE OR FAX:***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chesley | 519-363-2340 | Fax | 519-363-5798 | Durham | 519-369-2340 | Fax | 519-396-1478 |
| Kincardine | 519-396-3331 | Fax | 519-396-1478 | Walkerton | 519-881-1220 | Fax | 519-881-1388 |

**PATIENT INFORMATION**:

**Surname**: _____ **First Name**: _____ **Middle Initial**: ____

**Gender**: _____ **Date of Birth (YYYY-MM-DD):** _____

**Street Address**: _____ **Apartment**:____ **City**:_____ **Postal Code**:_____

**Telephone (Day)**: _____ **(Evening)**: _____ **(Cell)**: _____

**Health Card No. :** _____ **Version Code**:____

**Special Instruction** (Mobility, Communication etc); _____

## XRAY
Indicate side of interest in history

| | | | | |
|---|---|---|---|---|
| ☐ Facial Bones | ☐ Acute Abdomen | ☐ Pelvis | ☐ Finger/Thumb | ☐ Ankle |
| ☐ Orbit (pre MRI) | ☐ KUB | ☐ Hip | ☐ Forearm | ☐ OsCalcis |
| ☐ Nose | ☐ Cervical | ☐ Shoulder | ☐ Wrist | ☐ Foot |
| ☐ Soft Tissue Neck | ☐ Thoracic | ☐ Clavicle | ☐ Hand/Wrist | ☐ Toes |
| ☐ Chest | ☐ Lumbar | ☐ Scapula | ☐ Femur | ☐ Other_____ |
| ☐ Ribs | ☐ Sacrum/Coccyx | ☐ Humerus | ☐ Knee | |
| ☐ Sternum | ☐ SI Joints | ☐ Elbow | ☐ Tib Fib | |

## MAMMOGRAM
Kincardine/ Walkerton ***(Please do not wear any powder or deodorant)***

☐ Bilateral
☐ Right
☐ Left

**Recheck with:**
☐ CC Views
☐ Mag. Views

☐ Core Biopsy
☐ Breast Aspiration

## GASTRIC
*Walkerton*

☐ Ba Swallow
☐ UGI
☐ Sm. Bowel
☐ Ba Enema

*Nothing to eat or drink after midnight before exam* ➡ *Separate prep sheet to be provided by your physician*
➡ *Early fluid supper. Take 1 bottle of CITRO MAG about 5 p.m. Nothing to eat or drink after laxative.*
➡ *Early fluid supper. Take 1 bottle of CITRO MAG about 5:00 p.m. Nothing to eat or drink after laxative*

## BMD
Durham/Kincardine

Date of previous BMD_____ Location of previous BMD_____

☐ Baseline (never had a BMD before)
☐ Low Risk, One time only at 3 years following baseline
☐ Low Risk every 5 year
☐ Moderate Risk - Radiologist Recommendation
☐ High Risk, 1-2 years

History of fractures: _____
Osteoporosis Meds (type, duration) _____
Prednisone or Equiv. (type, dose, duration) _____
Calcium_____ Vitamin D_____

**HISTORY (Mandatory)**

**EMERGENCY DEPARTMENT USE ONLY** ☐ 24 hour ☐ 48 hours ☐ Next Available
☐ Return to ER for Follow UP ☐ Follow Up with Family Doctor

**PHYSICIAN SIGNED REQUISTION MUST BE PRESENTED TO TECHNOLOGIST AT TIME OF APPOINTMENT**

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Date** | **Physician Printed Name** | **Signature** | **Copies to:** |