Trillium Health Partners
Better Together

Diagnostic Imaging Requisition: X-Ray, Fluoroscopy & Bone Density (BMD)

PATIENT DEMOGRAPHICS:

Last Name: ______________________ First Name: _____________________________ Date of Birth (DD/MM/YYYY): _____/_____/______

Health Card #: ___________________________________ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: ______________________________________ City: ________________ Province: _____________ Postal Code: _____________

Telephone number: _________________________ Mobile number: ____________________ Email Address: _________________________

Mobility Status ☐ Ambulatory ☐ Assist w help ☐ Non-Ambulatory ☐ Assistive Device ☐ Wheelchair Weight (lbs): ___________________

Clinical Indication/Reason for Exam/Clinical History

X-Ray Request (No appointment required)

Abdomen

- ☐ 1 view Abdomen/KUB
- ☐ 3 view Abdomen

Head & Neck

- ☐ Skull
- ☐ Facial Bones
- ☐ Adenoids
- ☐ Panorex
- ☐ Mandible
- ☐ TM Joints
- ☐ Orbit for MRI
- ☐ Soft Tissue Neck

Chest

- ☐ Chest
- ☐ Ribs ☐ R ☐ L
- ☐ Sternum

Spine & Pelvis

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Scoliosis ☐ 1 view ☐ 2 views
- ☐ Sacrum/Coccyx
- ☐ S.I. Joints (Bilateral)
- ☐ Pelvis
- ☐ Hip ☐ R ☐ L

Lower Extremities

- ☐ Femur ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Tibia/Fibula ☐ R ☐ L
- ☐ Leg Length: ______________________
- ☐ Ankle ☐ R ☐ L
- ☐ Calcaneus ☐ R ☐ L
- ☐ Foot ☐ R ☐ L
- ☐ Toe No.____ ☐ R ☐ L

Upper Extremities

- ☐ AC Joint (Bilateral)
- ☐ Shoulder ☐ R ☐ L
- ☐ Clavicle ☐ R ☐ L
- ☐ Scapula ☐ R ☐ L
- ☐ Humerus ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Forearm ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Scaphoid ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Thumb ☐ R ☐ L
- ☐ Finger No.____ ☐ R ☐ L
- ☐ Other:

Fluoroscopy Procedures (By appointment only)

- ☐ Voiding Cystourethrogram
- ☐ Joint Injection drug & dose (guidance defined by radiologist):

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- ☐ Other:

Bone Density (By appointment only)

For Bone Density guidelines please refer to the following
https://www.cmaj.ca/content/182/17/1864.full

☐ Baseline ☐ Low Risk ☐ High Risk

Previous Bone Densitometry: ☐ Yes ☐ No

Location: ____

Date (dd/mm/yyyy):

REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name- as listed in CPSO): ____

Address: ____________________________ City: ____________________ Province: _____________ Postal Code: ______________

Phone number: _________________ Fax number: _______________ CPSO #: ______________ Billing (OHIP) #: _______________

Signature: ____________________________________ Date: __________________