



200 Fletcher Crescent
Alliston, Ontario L9R 1W7

FOR OUT PATIENT WALK INS 8am – 4pm MONDAY TO FRIDAY ONLY	
For Urgent Out Patients please call:	
Phone: 705-435-6281 Ext 0	Fax: 705-434-5112
Notes: _____	

DIAGNOSTIC IMAGING XRAY REQUISITION

Patient Name:	Health Card #:	VC:
Address:		
Phone #:	DOB: (dd/mm/yyyy)	
Referring Physician:	Phone #:	Fax #:
Physicians Signature:	Date of Referral: (dd/mm/yyyy)	
Clinical History / Indication Reason for Exam:		

General Radiography (X-RAY)		
Head/Neck	Upper Extremity	Lower Extremity
<input type="checkbox"/> Skull	<input type="checkbox"/> RT <input type="checkbox"/> LT Shoulder	<input type="checkbox"/> RT <input type="checkbox"/> LT Hip (includes pelvis)
<input type="checkbox"/> Sinuses (no OHIP)	<input type="checkbox"/> RT <input type="checkbox"/> LT Clavicle	<input type="checkbox"/> RT <input type="checkbox"/> LT Femur
<input type="checkbox"/> Adenoids	<input type="checkbox"/> RT <input type="checkbox"/> LT Scapula	<input type="checkbox"/> RT <input type="checkbox"/> LT Knee
<input type="checkbox"/> Neck for Soft Tissue	AC Joints	<input type="checkbox"/> RT <input type="checkbox"/> LT Patella
<input type="checkbox"/> Mastoids	<input type="checkbox"/> RT <input type="checkbox"/> LT Humerus	<input type="checkbox"/> RT <input type="checkbox"/> LT Tib/Fib
<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> RT <input type="checkbox"/> LT Elbow	<input type="checkbox"/> RT <input type="checkbox"/> LT Ankle
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> RT <input type="checkbox"/> LT Forearm	<input type="checkbox"/> RT <input type="checkbox"/> LT Foot
<input type="checkbox"/> Mandible	<input type="checkbox"/> RT <input type="checkbox"/> LT Wrist	<input type="checkbox"/> RT <input type="checkbox"/> LT Os Calcis
<input type="checkbox"/> TM Joints	<input type="checkbox"/> RT <input type="checkbox"/> LT Scaphoid	<input type="checkbox"/> RT <input type="checkbox"/> LT Digit/Toe: 1 2 3 4 5
<input type="checkbox"/> Orbits	<input type="checkbox"/> RT <input type="checkbox"/> LT Hand	Survey
Thorax/Abdomen/Pelvis	<input type="checkbox"/> RT <input type="checkbox"/> LT Digit/Finger: 1 2 3 4 5	<input type="checkbox"/> Osteo/Rheumatoid Arthritis
<input type="checkbox"/> Chest	Spine	<input type="checkbox"/> Metabolic/Skeletal
<input type="checkbox"/> Sternum	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Metastatic
<input type="checkbox"/> SC Joints	<input type="checkbox"/> Thoracic (Dorsal) Spine	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Thoracic Inlet/Outlet	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Leg Length
<input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bilateral Chest (PA) & Ribs	<input type="checkbox"/> Sacrum and Coccyx	<input type="checkbox"/> Babygram
<input type="checkbox"/> Abdomen-One View KUB	<input type="checkbox"/> SI Joints	
<input type="checkbox"/> Acute Abdomen-3 views	Bone Age: <input type="checkbox"/> Non-Dominant Hand	
<input type="checkbox"/> Pelvis		

