STEVENSON
MEMORIAL HOSPITAL

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