



X-Ray and Bone Density Requisition

Name: _____ M / F
 Address: _____
 Phone: (H) _____ (W) _____
 D.O.B. _____ Health Card #: _____
 Unit #: _____

Please arrive 20 minutes before your appt. Late arrival may affect or cancel your appt.

APPOINTMENT	Appointment LOCATION
Day: _____	<input type="checkbox"/> Georgetown Site 1 Princess Anne Dr., Georgetown, ON L7G 2B8 Phone: 905-873-0111 Fax: 905-873-4593
Date: _____ / _____ / _____ <small>Date Month Year</small>	<input type="checkbox"/> Milton Site 725 Bronte Street S., Milton ON L9T 9K1 Phone: 905-876-7023 Fax: 905-876-7003
Time: _____ a.m. _____ p.m.	<input type="checkbox"/> Oakville Site 3001 Hospital Gate, Oakville, ON L6M 0L8 Phone: 905-338-4604 Fax: 905-845-9921

Patient agrees for Halton Healthcare Services to leave test information on home telephone. Phone #: _____

Clinical Notes - (must be completed or test will be delayed) _____

X-Ray Request (no appointment required)

Abdomen <input type="checkbox"/> KUB <input type="checkbox"/> 3 View Abdomen Head & Neck <input type="checkbox"/> Skull <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bone <input type="checkbox"/> Mandible <input type="checkbox"/> TM Joints <input type="checkbox"/> Orbits for MRI <input type="checkbox"/> Soft Tissue Neck Chest <input type="checkbox"/> Chest <input type="checkbox"/> Ribs: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Sternum	Spine and Pelvis <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> S.I. Joints <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip: <input type="checkbox"/> R <input type="checkbox"/> L Lower Extremities <input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Calcaneus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Toe No. _____ <input type="checkbox"/> R <input type="checkbox"/> L	Upper Extremities <input type="checkbox"/> AC Joints (Bilateral) <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Clavicle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Scapula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Humerus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Scaphoid <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Thumb <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Finger No. _____ <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Skeletal Survey Other: _____
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Fluoroscopy / Gastric Procedures (by appointment only)

<input type="checkbox"/> Barium Swallow (OTMH)	<input type="checkbox"/> ERCP
<input type="checkbox"/> UGI (OTMH)	<input type="checkbox"/> Cysto (O.R.)
<input type="checkbox"/> SBFT (OTMH)	<input type="checkbox"/> Pacemaker Insertion (O.R.)
<input type="checkbox"/> UGI and Follow Through (OTMH)	<input type="checkbox"/> Ortho (O.R.)
<input type="checkbox"/> Barium Enema (OTMH)	<input type="checkbox"/> HSG
<input type="checkbox"/> Other _____	

Bone Density (by appointment only)

For Bone Density guidelines refer to The 2010 Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada.
<http://www.cmaj.ca/cgi/content/full/182/17/1864>
 Bone Density exams being done at a different hospital at Halton Healthcare would be a new baseline Bone Density as exam cannot be compared to previous.

Baseline
 Low Risk
 High Risk

Previous Bone Densitometry: Yes No

Location: _____
 Date: _____

Referring Physician: _____
 Phone #: _____
 Copy Report to: _____
 Physician's Signature: _____
 Date: _____

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