WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

# X-Ray Requisition

**INCOMPLETE REQUESTS WILL BE RETURNED, resulting in delay or cancellation of the procedure**
**♦ Fax Completed Requests to: 519-255-2125 ♦ For questions, call: 519-254-1727**

## Patient Information - Please Print or affix label

**Name**: _____ **Date of Birth** (mm/dd/yyyy):_____ **Sex**: ☐ M ☐ F

**Address**: _____ **WSIB**: _____

**Primary Contact #** (  ) _____ **Secondary #** (  ) _____

**Health Card #:** _____ **VC**:_____ **Weight**: _____ ☐ lb ☐ kg

**Patient arriving from external healthcare facility**: ☐ Y ☐ N **Height**: _____ ☐ ft ☐ in

## CLINICAL HISTORY - REQUIRED

## X-RAY - NO APPOINTMENT REQUIRED FOR THESE EXAMS

**CHEST**
☐ Chest
☐ Sternum
☐ SC Joints
RIBS: ☐ R ☐ L
☐ Lower ☐ Upper

**ABDOMEN**
☐ Single / Kub
☐ Series

**SPINE**
☐ Cervical Spine _____
☐ Thoracic Spine _____
☐ Lumber Spine _____
☐ Sacrum
☐ Coccyx
☐ Pelvis
☐ SI Joints
☐ Scoliosis Series

**UPPER EXTREMITIES**
☐ R ☐ L - Shoulder
☐ R ☐ L - Clavicle
☐ R ☐ L - AC Joints
☐ R ☐ L - Scapula
☐ R ☐ L - Humerus
☐ R ☐ L - Elbow
☐ R ☐ L - Forearm
☐ R ☐ L - Wrist
☐ R ☐ L - Hand
☐ R ☐ L - Fingers, specify:_____

**LOWER EXTREMITIES**
☐ R ☐ L - Hip
☐ R ☐ L - Femur
☐ R ☐ L - Knee
☐ R ☐ L - Patella
☐ R ☐ L - Tibia & Fibula
☐ R ☐ L - Ankle
☐ R ☐ L - Foot
☐ R ☐ L - Calcaneus
☐ R ☐ L - Toes, specify:_____
☐ R ☐ L - Leg Lengths

**HEAD**
☐ Skull
☐ Nasal Bones
☐ Soft Tissue Neck
☐ Orbits (MRI)
☐ Orbits (FB)

Other: _____

## Referring Physician Information & Signature

| Name | Signature | Date (mm/dd/yyyy) | Fax # |
|---|---|---|---|
| | | | |

**Physicians that require a copy of report:**_____

**Appointment:**

| **Date** (mm/dd/yyyy) | **Time** | **Campus** |
|---|---|---|
| | | |