WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

X-RAY REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure

Patient Information (Please Print)

Name: ____________________ Date of Birth (MM/DD/YYYY):____________ Sex: ☐ M ☐ F

Address: ____________________ WSIB: ____________ Patient's Weight: ______ lbs ______ Kgs

Primary Contact # ( ) ____________ Secondary # ( ) ____________ Patient's Height: ______ ft ______ in

Health Card #: ____________ Version ________ Patient arriving from external healthcare facility: ☐ Y ☐ N

CLINICAL HISTORY REQUIRED

X-RAY (NO APPOINTMENT REQUIRED FOR THESE EXAMS)

CHEST
- ☐ CHEST
- ☐ STERNUM
- ☐ SC JOINTS
- ☐ RIBS ☐ R ☐ L
- ☐ LOWER ☐ UPPER

SPINE
- ☐ CERVICAL SPINE ____________
- ☐ THORACIC SPINE ____________
- ☐ LUMBAR SPINE ____________
- ☐ SACRUM
- ☐ COCCYX
- ☐ PELVIS
- ☐ SI JOINTS
- ☐ SCOLIOSIS SERIES

ABDOMEN
- ☐ SINGLE / KUB
- ☐ 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 ☐ PATELLA
- ☐ R ☐ L TIBIA & FIBULA
- ☐ R ☐ L ANKLE
- ☐ R ☐ L FOOT
- ☐ R ☐ L CALCANEUS
- ☐ R ☐ L TOES - SPECIFY ____________
- ☐ R ☐ L LEG LENGTHS

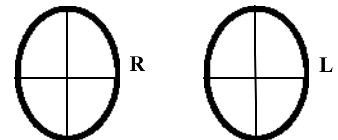
OTHER ☐ ____________

HEAD
- ☐ SKULL
- ☐ SINUSES
- ☐ FACIAL BONES
- ☐ NASAL BONES
- ☐ MANDIBLE
- ☐ PANOREX
- ☐ SOFT TISSUE NECK
- ☐ ORBITS (MRI)
- ☐ ORBITS (FB)

BREAST IMAGING *DIGITAL

- ☐ MAMMOGRAM ☐ R ☐ L ☐ BILATERAL
- ☐ BREAST ULTRASOUND ☐ R ☐ L ☐ BILATERAL
- ☐ MAMMOGRAM AND BREAST ULTRASOUND ☐ R ☐ L ☐ BILATERAL
- ☐ BIOPSY BREAST ☐ R ☐ L
- ☐ DUCTOGRAM
- ☐ OBSP

REGION OF INTEREST



PREVIOUS BREAST EXAM DONE WHERE / WHEN: ____________

Print Referring Physician____________ Fax Number: ____________

Referring Physician Signature: ____________

Physicians who require copy of report: ____________

APPOINTMENT:
DATE (MM/DD/YYYY):____________ **TIME:** ________ **CAMPUS:** ____________