



**Medical Imaging Department
 REQUISITION
 X-RAY, ULTRASOUND, BREAST IMAGING,
 BMD, NUCLEAR MEDICINE**

FORM SF0180 Page 1 of 2 Rev. 05/2020

Patient LABEL / Identification Area

Apt Date:	Apt Time:	Initial
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Clinical Information/Indication for test: _____

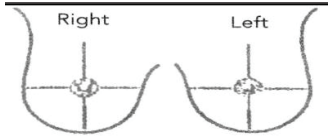
X-RAY open 7 days a week 8am – 8pm . No appointment needed (P) 416-756-6167 (F) 416-756-6370

<u>Chest & Abdomen</u>	<u>Spine</u>	<u>Head & Neck</u>	<u>Skeletal Survey</u>
<input type="checkbox"/> Chest PA & Lat <input type="checkbox"/> Ribs <input type="checkbox"/> R <input type="checkbox"/> L & Chest PA <input type="checkbox"/> Abd Single View (KUB) <input type="checkbox"/> Abd Series (2V) & Chest PA	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum & Coccyx <input type="checkbox"/> Scoliosis <input type="checkbox"/> AP <input type="checkbox"/> AP/LAT	<input type="checkbox"/> Skull <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Metastatic <input type="checkbox"/> Bone Age Study Other _____
<p><u>Upper Extremity</u></p> <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Clavicle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Scapula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Scaphoid <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> AC Joints (Bilateral) <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Humerus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Fingers <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L #1 2 3 4 5		<p><u>Lower Extremity</u></p> <input type="checkbox"/> Pelvis <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Calcaneus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Knee/Standing <input type="checkbox"/> Toe <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L #1 2 3 4 5 <input type="checkbox"/> Bilat Standing PA <input type="checkbox"/> Bilat Standing Leg Flexion Length (hip to ankle)	

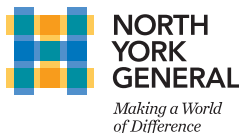
ULTRASOUND (P) 416-756-6176 (F) 416-756-6370

<input type="checkbox"/> Abdomen Complete <input type="checkbox"/> Abdomen Limited (GB, Liver, Renal etc.) <input type="checkbox"/> Pelvis(Transabdominal) <input type="checkbox"/> Transvaginal <input type="checkbox"/> Transrectal <input type="checkbox"/> Testicle <input type="checkbox"/> Hysterosonogram <input type="checkbox"/> Thyroid/ Face & Neck <u>Obstetrical – Date of LMP</u> _____ <input type="checkbox"/> Dating IPS NT <input type="checkbox"/> Anatomical <input type="checkbox"/> Pregnancy Medically Indicated	<u>Doppler :</u> <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilateral <input type="checkbox"/> Carotid <input type="checkbox"/> Arterial Upper / Lower Extremity <input type="checkbox"/> Venous Upper / Lower Extremity <u>Neonatal</u> <input type="checkbox"/> Neonatal Brain <input type="checkbox"/> Hips <input type="checkbox"/> Spine <u>MSK:</u> <input type="checkbox"/> R <input type="checkbox"/> L Extremity : _____ Other: _____
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BREAST IMAGING SERVICES (P) 416-756-6931 (F) 416-756-6358

<input type="checkbox"/> Routine Screening (Including OBSP) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Diagnostic Mammogram <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Diagnostic Ultrasound Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Does patient have Breast Implants <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previous Imaging <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____	Please indicate area of concern 
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Please send all previous breast imaging reports with requisition



General Site-4001 Leslie Street
Toronto On M2K 1E1

Outpatient & Community Services Centre
South Entrance-2 Champagne Drive
Toronto On M3J 0K2

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BMD, NUCLEAR MEDICINE**

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Patient LABEL / Identification Area

BONE MINERAL DENSITOMETRY (BMD) (P) 416-756-6931 (F) 416-756-6358

Baseline Low Risk High Risk Last BMD Date: _____

NUCLEAR MEDICINE (P) 416-756-6258 (F) 416-756-5995

- Bone Scan:** Whole Body Specific Site
- Gallium Scan:** Whole Body Specific Site
- Thyroid:** Uptake & Scan Scan Only Uptake Only
- Parathyroid:** Scan
- Liver :** Hemangioma (RBC) Liver / Spleen (Sulfur Colloid)
- Renal:** Scan Captopril (HTN) Lasix (? Obstruction)
- Brain Scan SPECT
- Biliary Scan (HIDA)
- Lung Scan (V/Q)
- Meckels
- Gastric Emptying Scan
- Salivary Scan
- I-131 Whole Body Scan
- Cardiac - Pyrophosphate Scan (Amyloid protocol)
- Other _____

Provider Information

Physician Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

CPSO Number: _____

Copy To: _____

Physician
Signature: _____

Date: _____

- **By the use and submission of this requisition, the MRP is acknowledging that NYGH can use telephone, text message, or email communication to schedule and coordinate appointments.**
- **Interpreter recommended for non-English speaking patients.**

I approve the radiologist to order additional examinations related to the current investigation on my behalf. Physician Initials: _____

For all online requisitions and preparation instructions please visit www.nygh.on.ca/medicalimaging

- MRI** – Phone: 416-756-6118 Fax: 416-756-6353
- Cardio- Resp** : Phone: 416-756-6064 Fax: 416-756-6066
- Interventional/Fluoroscopy** - Phone: 416-756-6189 Fax 416-756-6766
- Pre-Op Breast Localization, Thyroid Biopsy:** Phone: 416-756-6172 Fax: 416-756-6370
- Breast Imaging:** Phone: 416-756-6931 Fax: 416-756-6358
- Third Party:** Phone: 416-756-6823 Fax: 416-756-6399
- General X-ray** : Phone: 416-756-6167 (No appointments necessary. Open 7 days/wk 8am – 8pm)
- Ultrasound** -: Phone: 416-756-6176 Fax: 416-756-6370