NORTH YORK GENERAL
Making a World of Difference

General Site-4001 Leslie Street
Toronto On M2K 1E1

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

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

FORM SF0180 **Rev. 09/2024**

Patient LABEL / Identification Area

Patient Name: ______________________________

Mobility: ❑ Wheelchair ❑ Non-ambulatory

Special Considerations: ______________________

Clinical Information/Indication for Procedure:

____

____

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

Chest & Abdomen
- ❑ Chest PA & Lat
- ❑ Ribs ❑ R ❑ L & Chest PA
- ❑ Abd Single View (KUB)
- ❑ Abd Series (2V) & Chest PA

Spine
- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar
- ❑ Sacrum & Coccyx
- ❑ Scoliosis
  - ❑ AP ❑ AP/Lat

Head & Neck
- ❑ Skull
- ❑ Facial Bones
- ❑ Nasal Bones
- ❑ Mandible
- ❑ Soft Tissue Neck

Skeletal Survey
- ❑ Metastatic
- ❑ Bone Age Study

Other: ______________________

Upper Extremity
- ❑ Shoulder ❑ R ❑ L
- ❑ Clavicle ❑ R ❑ L
- ❑ Scapula ❑ R ❑ L
- ❑ AC Joints (Bilateral)
- ❑ Humerus ❑ R ❑ L
- ❑ Elbow ❑ R ❑ L
- ❑ Forearm ❑ R ❑ L
- ❑ Wrist ❑ R ❑ L
- ❑ Scaphoid ❑ R ❑ L
- ❑ Hand ❑ R ❑ L
- ❑ Fingers ❑ R ❑ L
  # 1 2 3 4 5
  Indicate Finger #

Lower Extremity
- ❑ Pelvis
- ❑ Hip ❑ R ❑ L
- ❑ Femur ❑ R ❑ L
- ❑ Knee ❑ R ❑ L
- ❑ Knee/Standing
  ❑ R ❑ L
- ❑ Bilateral Standing PA Flexion
- ❑ Tibia/Fibula ❑ R ❑ L
- ❑ Ankle ❑ R ❑ L
- ❑ Foot ❑ R ❑ L
- ❑ Calcaneus ❑ R ❑ L
- ❑ Toe ❑ R ❑ L
  #1 2 3 4 5
- ❑ Bilateral Standing Leg Length (hip to ankle)

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

- ❑ Abdomen Complete
- ❑ Abdomen Limited (GB, Liver, Renal etc.)
- ❑ Pelvis (Transabdominal)
- ❑ Transvaginal
- ❑ Transrectal
- ❑ Testicle
- ❑ Hysterosonogram
- ❑ Thyroid/Face & Neck

Obstetrical – Date of LMP _______
- ❑ Dating IPS NT (12-14 weeks)
- ❑ Anatomical (18-20 weeks)
- ❑ Pregnancy (Medically Indicated)

Doppler: ❑ R ❑ L ❑ Bilateral
- ❑ Carotid
- ❑ Arterial Upper/Lower Extremity
- ❑ Venous Upper/Lower Extremity

Neonatal
- ❑ Neonatal Brain
- ❑ Hips
- ❑ Spine

MSK
❑ R ❑ L Extremity: ______________________

Other: ________________________________

BREAST IMAGING SERVICES (P) 416-756-6931 (F) 416-756-6358

❑ Routine Screening (Including OBSP)	❑ R	❑ L
❑ Diagnostic Mammogram	❑ R	❑ L
❑ Diagnostic Ultrasound Breast	❑ R	❑ L
❑ Does Patient have Breast Implants?	❑ Yes	❑ No
❑ Previous Imaging	❑ Yes	❑ No Location: _________

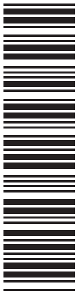
Please indicate area of concern

Right Left

Please send all previous breast imaging reports with requisition

DATE	TIME (24 h)	SIGNATURE	PRINT NAME

Approved By: Medical Imaging Manager; Approval Date: 09/2024 (archive: 10/2019)



General Site-4001 Leslie Street
Toronto On M2K 1E1

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

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

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	❑ RBC (Hemangioma)	❑ Liver/Spleen (Sulfur Colloid)	
Renal:	❑ Scan	❑Captopril (? Hypertension)	❑ Lasix (? UPJ Obstruction)

❑ Brain Scan SPECT
❑ Hepatobiliary Scan (HIDA)
❑ Lung Scan (V/Q) ❑Perfusion only
❑ Meckel's Diverticulum
❑ Gastric Emptying Study
❑ Salivary Scan
❑ I-131 Whole body Scan
❑ Cardiac – Myocardial Pyrophosphate Scan (Amyloid protocol)
❑ Other: _____________

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	(P) 416-756-6118	(F) 416-756-6353
Cardio-Respiratory	(P) 416-756-6064	(F) 416-756-6066
Interventional/Fluoroscopy	(P) 416-756-6189	(F) 416-756-6766
Pre-Op Breast Localization, Thyroid Biopsy	(P) 416-756-6172	(F) 416-756-6370
Breast Imaging	(P) 416-756-6931	(F) 416-756-6358
Third Party	(P) 416-756-6823	(F) 416-756-6399
General X-Ray	(P) 416-756-6167 (No appointment necessary. Open 7 days/wk 8am-8pm)	
Ultrasound	(P) 416-756-6176	(F) 416-756-6370

DATE	TIME (24 h)	SIGNATURE	PRINT NAME

Approved By: Medical Imaging Manager; Approval Date: 09/2024 (archive: 10/2019)