This Requisition Form Can be taken to any Licenced facility providing Healthcare Service.

Limeworth X-Ray and Ultrasound

MAMMOGRAPHY & BONE DENSITY

849 Upper Wentworth St., Suite 102
Hamilton, Ontario L9A 5H4
(Between Mohawk and Limeridge Mall)

Mon, Tues & Thurs	8:00am - 6:00pm
Wednesday	8:00am - 5:00pm
Friday	8:00am - 5:00pm
Saturday	8:00am - 4:00pm

Tel: 905-574-7755 Fax: 905-574-0384 Email: 849xray@gmail.com

Your Appointment

DAY: _____

DATE: _____

TIME: _____

❑ X RAY REQUEST (Walk-in)

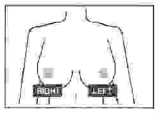
ABDOMEN
- ❑ K.U.B. (1 View)
- ❑ 3 Views

HEAD & NECK
- ❑ Skull
- ❑ Sinuses (Not covered by OHIP)
- ❑ Adenoids
- ❑ Adenoid/Soft Tissues Of Neck
- ❑ Mastoids
- ❑ Facial Bones
- ❑ Nasal Bone
- ❑ Orbits
- ❑ Mandibles
- ❑ T.M. Joints

CHEST
- ❑ Chest
- ❑ Ribs ❑ L ❑ R
- ❑ Sternum
- ❑ S.C. Joint

SPINE & PELVIS
- ❑ Cervical Spine
- ❑ Thoracic Spine
- ❑ Lumbar Spine
- ❑ Sacrum & Coccyx
- ❑ S.I. Joints
- ❑ Pelvis
- ❑ Pelvis & Hips ❑ L ❑ R
- ❑ BONE AGE
- ❑ SCOLIOSIS

SKELETAL SURVEY
- ❑ Metastatic series
- ❑ Arthritic series



Please **DO NOT USE** Deodorant before examination

MAMMOGRAPHY & BREAST IMAGING
- ❑ OBSP
- ❑ SCREENING
- ❑ DIAGNOSTIC
- ❑ BREAST ULTRASOUND ❑ L ❑ R

UPPER EXTREMITES
- ❑ L ❑ R Clavicle
- ❑ L ❑ R A.C. Joints
- ❑ L ❑ R Shoulders
- ❑ L ❑ R Scapula
- ❑ L ❑ R Humerus
- ❑ L ❑ R Elbow
- ❑ L ❑ R Forearm
- ❑ L ❑ R Wrist
- ❑ L ❑ R Hand
- ❑ L ❑ R Thumb
- ❑ L ❑ R Finger No. 1 2 3 4 5

LOWER EXTREMITES
- ❑ L ❑ R Hip
- ❑ L ❑ R Femur
- ❑ L ❑ R Knee
- ❑ L ❑ R Tib & Fib
- ❑ L ❑ R Ankle
- ❑ L ❑ R Foot
- ❑ L ❑ R Calcaneus
- ❑ L ❑ R Toe No. 1 2 3 4 5

BONE DENSITY (DEXA)
- ❑ Baseline
- ❑ High risk management after1 year
- ❑ Low risk after 5 years
- ❑ Date of last exam

_____
Day | Month | Year

❑ ULTRASOUND REQUEST
By Appointment Only

• ABDOMEN
- ❑ Complete
- ❑ Liver
- ❑ Gallbladder
- ❑ Kidneys
- ❑ Aorta
- ❑ Spleen
- ❑ Appendix
- ❑ Hernia

• PELVIC
- ❑ Male Pelvic
- ❑ Transrectal
- ❑ Testicular/Scrotum
- ❑ Female Pelvic
- ❑ Transvaginal
- ❑ Bladder

• NECK
- ❑ Thyroid
- ❑ Neck

• OBSTETICS
- ❑ OB Dating (<16 WKS)
- ❑ IPS/EFTS (11-13 WKS)
- ❑ OB Routine (18-22 WKS)
- ❑ Third Trimester _____

• MUSCULOSKELETAL
- ❑ L ❑ R Shoulder
- ❑ L ❑ R Elbow
- ❑ L ❑ R Wrist
- ❑ L ❑ R Hand
- ❑ L ❑ R Hip
- ❑ L ❑ R Leg
- ❑ L ❑ R Knee
- ❑ L ❑ R Ankle
- ❑ L ❑ R Foot
- ❑ L ❑ R Other

X-RAY PREGNANCY RELEASE FORM

I declare to the best of my knowledge that I am NOT presently pregnant.

_____
Signature of Patient

Total images _____

X-Ray Exp.

	KVP	MAS
P.A.	_____	_____
LaT	_____	_____

Fluoro Time ( )

Shielding ( )

Tech. _____

Other Examination or Views _____

PATIENTS LAST NAME		FIRST NAME	
HEALTH CARD NUMBER		DATE OF BIRTH D M Y	Telephone

Clinical Information _____

Date: _____ Referred By: _____ Signature _____

Please bring Health Card and This Requisition

Please call 24 hours in advance if you need to change your appointment to avoid cancellation fee. Please arrive 15 minutes before appointment.