DIAGNOSTIC StL IMAGING

Telephone: 1-800-268-5804
Toll Free Fax: 1-855-374-3497
www.stlimaging.ca

HOME NAME (NO ABBREVIATIONS)	PHONE NUMBER

ADDRESS FOR SERVICE	UNIT NAME / ROOM #

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	SEX
		F M

HEALTH NUMBER	VERSION CODE	DATE OF BIRTH
		DD MM YY

☐ **Receiving Ontario Health atHome (Formerly HCCSS)**

MOBILE X-RAY

☐ CHEST
☐ RIBS L R

☐ ABDOMEN VIEWS* 1 ☐ 3 ☐
☐ CERVICAL SPINE
☐ THORACIC SPINE
☐ LUMBAR SPINE*
☐ SACRUM / COCCYX*
☐ SI JOINTS*
☐ PELVIS & HIPS* L R
☐ FEMUR L R
☐ KNEE L R
☐ TIB-FIB L R
☐ ANKLE L R
☐ CALCANEUS L R
☐ FOOT L R
☐ _____ TOE L R

☐ SKULL L R
☐ FACIAL BONES L R
☐ NASAL BONES L R
☐ ORBITS L R
☐ MANDIBLE L R
☐ CLAVICLE L R
☐ SHOULDER L R
☐ AC JOINTS L R
☐ HUMERUS L R
☐ ELBOW L R
☐ FOREARM L R
☐ WRIST L R
☐ HAND L R
☐ _____ DIGITS L R

(Weight Restrictions 90 KG/200 LB)*

MOBILE ULTRASOUND

☐ ABDOMEN
☐ ABDOMEN LIMITED
_____
☐ ABDOMEN/PELVIS
☐ PELVIS
☐ SCROTUM
☐ GROIN (Hernia)
☐ THYROID
☐ NECK
☐ SALIVARY GLAND
Site _____

DOPPLER
☐ VENOUS ARMS L R
☐ VENOUS LEGS L R
☐ ARTERIAL LEGS L R
☐ ARTERIAL ARMS L R
☐ CAROTID L R

☐ LUMP / MASS
Site _____

☐ OTHER
_____
_____
_____

(Prep on Reverse)

CLINICAL INFORMATION
REASON FOR EXAMINATION - (RELEVANT MEDICAL HISTORY)

INFECTION CONTROL PRECAUTIONS ☐ YES ☐ NO

☐ **URGENT**

MEDICAL PRACTITIONER / RNEC	OHIP BILLING NO.	UNIT NAME & EXT.
Please print First Name Last Name		

PHYSICIAN'S / RNEC'S SIGNATURE	DATE
X	DD MM YY