Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING– **XRAY**

Tel: 613-354-3301 x263; Fax: 613-354-4331

Patient Name:

DOB:
HCN:
Address:
Phone/Cell #:

☐ Non OHIP Patient:

☐ WSIB #:

Physician Name: ______________________

Physician Signature: ______________________

OHIP Billing Physician Name/#: ______________________

Physician Contact #: ______________________

Physician Fax #: ______________________

Date of Referral: ______________________

Report Copies To: ______________________

****Message capable Physician phone # to confirm receipt of urgent results:**

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**if absent, urgent result receipt confirmation delays may occur

INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY

ALL XRAY EXAMS ARE BY WALK IN * BETWEEN THE HOURS OF 0730 AND 2100 *

CLINICAL INDICATION:

Requested date/time frame:

P1 = Within 24hr ***# required*

P2 = Within 48hr ***# required*

P3 = Within 10 days

P4 = Routine

CHEST

☐ Chest – Routine
☐ Sternum
☐ S.C. Joints
Ribs ☐ RT ☐ LT

ABDOMEN

☐ Acute Abdomen
☐ KUB/Flat Plate

HEAD & NECK

☐ Orbits for MRI
☐ Skull
☐ Facial Bones
☐ Nasal Bones
☐ Mandible
☐ Soft Tissue Neck

UPPER EXTREMITIES

Clavicle	☐ RT	☐ LT
Shoulder	☐ RT	☐ LT
Scapula	☐ RT	☐ LT
A.C. Joints	☐ RT	☐ LT
Humerus	☐ RT	☐ LT
Elbow	☐ RT	☐ LT
Forearm	☐ RT	☐ LT
Wrist	☐ RT	☐ LT
Scaphoid & Wrist	☐ RT	☐ LT
Hand	☐ RT	☐ LT
Finger 1 2 3 4 5	☐ RT	☐ LT

SKELETAL SURVEY

** Complete CT request
→ Whole Body (Ultra Low Dose)
http://web.lacgh.napanee.on.ca/professionals/lacgh-patient-requisition-forms/

LOWER EXTREMITIES

Femur	☐ RT	☐ LT
Knee	☐ RT	☐ LT
Tibia & Fibula	☐ RT	☐ LT
Ankle	☐ RT	☐ LT
Foot	☐ RT	☐ LT
Calcaneus	☐ RT	☐ LT
Toe 1 2 3 4 5	☐ RT	☐ LT

SPINE & PELVIS

☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ S.I. Joints
☐ Sacrum/Coccyx
☐ Pelvis
Hip ☐ RT ☐ LT

Appointment Date: **(DD/MM/YY) Time:** **Date Received:** **Date Notified:**