DIAGNOSTIC IMAGING – RADIOLOGY (X-Ray)

Huntsville District Memorial Hospital
100 Frank Miller Drive
Huntsville, ON P1H 1H7
T: 705-789-2311 x2242
F: 705-788-1485
Open Monday to Friday
8 a.m. to 4:30 p.m.

South Muskoka Memorial Hospital
75 Ann Street
Bracebridge, ON P1L 2E4
T: 705-645-4404 x3112
F: 705-645-7567
Open Monday to Friday
8 a.m. to 4:30 p.m.

Almaguin Highlands Health Centre
150 Huston Street
Burk's Falls, ON P0A 1C0
T: 705-704-9999 x4002
F: 705-788-1485
Open Mondays, Tuesdays, Thursdays
8:30 a.m. to 4:30 p.m.

Note to Patient:
X-ray services are a walk-in only service.
There may be a wait for your walk-in exam. A requisition is required to complete your exam.

Patient Demographics:

Name Last First

Address

Home Phone ( ) - Other Phone ( ) -

☐ **Do not contact patient.** Provide appointment date/time to referring provider.

DOB YYYY / MM / DD ☐ Male ☐ Female

OHIP

Isolation Precautions: ☐ Contact ☐ Droplet/Contact ☐ Airborne

Special Instructions (mobility, communication, etc): _____ ☐ Falls Risk ☐ Hoyer Lift

Relevant Clinical History:

WSIB claim #:_____

- ☐ Skull
- ☐ Facial Bones
- ☐ Pre MRI Orbits
- ☐ Nasal Bones
- ☐ Mandible
- ☐ TMJs
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum/Coccyx
- ☐ SI Joints
- ☐ Scoliosis
- ☐ Leg Length

- ☐ Chest (PA/Lat)
- ☐ Chest (PA)

R	L	
☐	☐	Ribs
☐	☐	SC Joints
	☐	Sternum
	☐	Abdomen (KUB)
	☐	Abdomen Acute

R	L	
☐	☐	Shoulder
☐	☐	Scapula
☐	☐	Clavicle
☐	☐	Humerus
☐	☐	AC Joints

R	L	
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Hand
	☐	Pelvis
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tibia/Fibula
☐	☐	Ankle
☐	☐	Os Calcis
☐	☐	Foot

☐ Other:

		1	2	3	4	5
Lower Digits	R	☐	☐	☐	☐	☐
Lower Digits	L	☐	☐	☐	☐	☐
Upper Digits	R	☐	☐	☐	☐	☐
Upper Digits	L	☐	☐	☐	☐	☐

Interventional Procedures
Scheduled appointment required.
Please fax requisition.

*Preparation to be given at time of booking.

- ☐ UGI* ☐ Barium Swallow*
- ☐ Marshmallow Swallow*
- ☐ Colon-Air*

Patient must bring steroid/ injectable meds with them to appointment. **Please indicate on requisition name of injectable medication, concentration, and amount to be injected.

- ☐ Joint Injection**

Specify Joint: _____

- ☐ PICC Line Single Lumen
- ☐ PICC Line Double Lumen

Referring Provider:	Signature:	
Copies:	Date:	OHIP Billing #:

VERSION: July 2024