WELL Health | DIAGNOSTIC CENTRES

REQUEST FOR EXAMINATION – SUDBURY RADIOLOGY

☐ Sudbury Elm
40 Elm Street, Suite 129
T: 705-673-2565 | F: 705-673-4482

☐ Sudbury Lasalle
1122 Lasalle Boulevard, Suite 107
T: 705-560-1114 | F: 705-560-7191

☐ Sudbury Long Lake
2009 Long Lake Road, Suite 103
T: 705-523-1295 | F: 705-523-2012

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Check if Applicable: ☐ URGENT ☐ WSIB

Full Name (Printed on Health Card): _____ Preferred Full Name (If Different Than Health Card): _____

Date of Birth: _____ Health Card #: _____ Version: _____

Gender (Birth): _____ Preferred Gender (If Different from Birth): _____ Height (cm): _____ Weight (kg): _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Cell Phone: _____ Alt. Phone: _____

Reason for Referral:

X-RAY (WALK-IN SERVICE)

ABDOMINAL
- ☐ Single/KUB
- ☐ Acute (Incl. PA chest)

CHEST
- ☐ Chest PA & LAT
- ☐ Ribs: ○ R ○ L
- ☐ Sternum
- ☐ Immigration Chest (Not insured by OHIP)

HEAD & NECK
- ☐ Soft Tissue Neck
- ☐ Skull
- ☐ Sinuses (Not insured by OHIP)
- ☐ Facial Bones
- ☐ Nose
- ☐ Mandible
- ☐ Orbits
- ☐ T.M. Joints
- ☐ Adenoids

LOWER EXTREMITIES

R L
- ☐ ☐ Hip
- ☐ ☐ Femur
- ☐ ☐ Knee
- ☐ ☐ Tib. & Fib.
- ☐ ☐ Ankle
- ☐ ☐ Foot
- ☐ ☐ Calcaneus
- ☐ ☐ Toe: 1 2 3 4 5

SPINE & PELVIS
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar (L/S) Spine
- ☐ Sacrum/Coccyx
- ☐ S.I. Joints
- ☐ Pelvis
- ☐ Scoliosis Series

UPPER EXTREMITIES

R L
- ☐ ☐ Shoulder
- ☐ ☐ Clavicle
- ☐ ☐ Sternoclavicular joints
- ☐ ☐ A.C. Joint
- ☐ ☐ Scapula
- ☐ ☐ Humerus
- ☐ ☐ Elbow
- ☐ ☐ Forearm
- ☐ ☐ Wrist
- ☐ ☐ Scaphoid
- ☐ ☐ Hand
- ☐ ☐ Finger: 1 2 3 4 5

OTHER
- ☐ Leg Lengths
- ☐ Skeletal Survey
- ☐ Bone Age
- ☐ NEJAC Protocol
- ☐ Indicate: _____

NUCLEAR CARDIOLOGY (SUDBURY ELM)

MYOCARDIAL PERFUSION
- ☐ Exercise
- ☐ Persantine

BONE MINERAL DENSITY (SUDBURY ELM)

- ☐ Baseline
- ☐ Follow Up

ULTRASOUND

GENERAL ULTRASOUND
- ☐ Abdomen (Incl. limited bladder + lower quadrants, no reproductive organs)
- ☐ Abdomen + Pelvis (Incl. reproductive organs)
- ☐ Female Pelvis (Incl. Transvaginal)
- ☐ Male Pelvis (Excl. Transrectal)
- ☐ Screening Abdominal Aortic Aneurysm
- ☐ Renal*
- ☐ Bladder*
- ☐ Hernia: ○ Inguinal ○ Abdominal
- ☐ Other: _____

*Baseline abdominal ultrasound may be performed

OBSTETRICAL

EDC (Required): _____
- ☐ OB Series - Dating, Prenatal Screening, Anatomy
- ☐ Dating (< 16 weeks)
- ☐ Prenatal Screening (IPS/eFTS 11-13 weeks)
- ☐ Anatomy (18-20 weeks)
- ☐ Fetal Growth (30+ weeks): ○ BPP ○ UA Doppler ○ MCA Doppler
- ☐ Follicle Monitoring

SMALL PARTS
- ☐ Salivary Glands
- ☐ Thyroid
- ☐ Chest
- ☐ Groin: ○ R ○ L
- ☐ Inguinal Canal: ○ R ○ L
- ☐ Testes/Scrotum
- ☐ Soft Tissue/Lump (specify site): _____

MUSCULOSKELETAL

R L
- ☐ ☐ Shoulder
- ☐ ☐ Elbow
- ☐ ☐ Wrist
- ☐ ☐ Hip (Bursitis)
- ☐ ☐ Hamstring
- ☐ ☐ Knee
- ☐ ☐ Ankle
- ☐ ☐ Achilles Tendon
- ☐ ☐ Plantar Fascia
- ☐ ☐ Other: _____

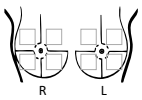
VASCULAR

R L
- ☐ ☐ Venous - Lower Extremity (DVT)
- ☐ ☐ Venous - Upper Extremity (DVT)
- ☐ ☐ Arterial - Lower Extremity (ABI)
- ☐ ☐ Arterial - Upper Extremity
- ☐ Carotid
- ☐ Renal Arteries
- ☐ Portal Venous Doppler
- ☐ Aorta: _____

☐ **OTHER:** _____

MAMMOGRAPHY & BREAST IMAGING

- ☐ Targeted Breast Ultrasound (indicate quadrant on diagram): ○ R ○ L
- ☐ Mammogram: ○ R ○ L ○ Implants



REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)

Referring Provider (Print Name): _____ Billing Provider #: _____ CPSO #: _____

Tel #: _____ Fax #: _____

Date: _____ Copy To: _____

Report Delivery Preference: ☐ Fax ☐ HRM ☐ Other: _____

Access your patient radiology reports at **WELLdiagnostics.ca/Access**

Referring Provider Signature:

For location details, visit **WELLdiagnostics.ca/Locations**

For test preparation, visit **WELLdiagnostics.ca/Test-Prep**

This requisition form can be submitted to any licensed Ontario healthcare facility, including hospitals and Integrated Community Health Services Centres: Health.gov.on.ca
Northern Health Travel Grant: Health.gov.on.ca/en/public/publications/ohip/northern.aspx