

X-RAY & ULTRASOUND Requisition Form

PATIENT INFORMATION

Last Name: _____ First Name: _____
 Date of Birth (DD/MM/YYYY): _____ Sex: ☐ M ☐ F
 Address: _____ City: _____ Postal Code: _____
 OHIP #: _____ Version Code: _____ Telephone: _____

REFERRING PHYSICIAN

Physician Name: _____
 Billing #: _____ Phone: _____ Fax: _____
 C.C. Dr: _____ ☐ Verbal Report

Please fax all completed requisitions to: 416-438-6358
Contact@sanovahealth.ca

Ultrasound (By appointment only)

1. Abdomen

- ☐ G.B. & Biliary System
☐ Liver
☐ Pancreas
☐ Spleen
☐ Abdominal Aorta
☐ Kidneys

2. Obstetrics

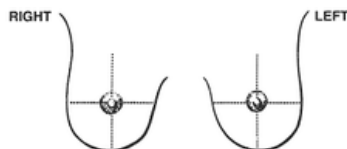
- (L.M.P. _____)
☐ Dating ☐ IPS (11–13
 wks) ☐ Complete ☐ High
 Risk ☐ BPP

3. Pelvis: ☐ Transvaginal

- 4. Prostate:** ☐ Transrectal
5. Pre & Post Void Volume ☐
6. Neck:
☐ Thyroid
☐ Salivary Glands
☐ Neck Mass

7. Scrotum ☐

8. Breast: ☐ Bilateral ☐ R ☐ L



9. Musculoskeletal (joints)

- R L
☐ Shoulder
☐ Elbow
☐ Wrist
☐ Knee
☐ Ankle/Foot
☐ Hip
☐ Groin
☐ Other _____

X-RAY (No appointment needed)

11. Bone Density

- (by appointment)
☐ Baseline ☐ Low Risk
 (3 yrs) ☐ Low Risk (5 yrs)
☐ High Risk (1 yr)

12. Abdomen

- ☐ Single View ☐ Acute (2
 views)

13. Chest

- ☐ Chest (PA & LAT)
☐ Ribs ☐ Sternum
☐ S.C. Joints

14. Head

- ☐ Skull ☐ Sinuses ☐ Mastoids
☐ Soft Tissue Neck
☐ Adenoids ☐ Pituitary Fossa
☐ Facial Bones ☐ Nasal Bones
☐ Mandible
☐ T.M. Joints ☐ Orbit ☐ Orbit
 pre-MRI

15. Spine

- ☐ Cervical ☐ Thoracic ☐
 Lumbar ☐ S.I. Joints ☐
 Sacrum/Coccyx ☐ Pelvis

16. Upper Extremities

- R L ☐ Shoulder ☐ Clavicle ☐ A.C.
 Joints ☐ Scapula
☐ Humerus ☐ Elbow ☐ Forearm ☐
 Wrist ☐ Scaphoid ☐ Hand
☐ Fingers 1–5

17. Lower Extremities

- R L ☐ Hip ☐ Femur ☐ Knee ☐
 Tib/Fib
☐ Ankle ☐ Foot ☐ Heel ☐ Toes 1–5

18. Skeletal Survey

- ☐ Arthritis ☐ Metastatic ☐ Bone Age

SIGNATURE

Referring Physician Signature: _____
 Date: _____

PREGNANCY RELEASE

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