DIAGNOSTIC IMAGING REQUISITION

2675 Concession Rd. Kemptville, ON K0G 1J0
Phone: 613-258-6133 Ext. 400 **OR** Fax: 613-258-4997
Fax all Requisitions. By appointment only.
Day, Evening & Weekends are available for most tests

Please bring your Health Card and this Requisition
Register at the Welcome Centre in the Emergency Department

OHIP #	**Circle one: Routine Semi-Urgent Urgent**
Name:	☐ **Bone Mineral Densitometry** ☐ **Screening Mammogram Only (no Diagnostic)** [1] ☐ **X-Ray** [2]
D.O.B: Mo: Day: Year:	Exam(s) Requested:_____
Address:	_____
Phone #:	_____
MANDATORY: Additional Precautions ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **None** ☐ **Droplet/Contact**	_____

ULTRASOUND EXAMS (Please fax requests) – No breast ultrasound

☐ **Abdominal:**	Liver, gallbladder, aorta, pancreas, kidneys, spleen - Do not eat or drink 6 hours prior. No chewing gum or candy. Medication may be taken with a sip of water. No smoking
☐ **Renal:**	Kidneys, ureters, bladder - Do not eat 6 hours prior but must drink 40 oz of water finishing 1 hour prior to arrival. Arrive with a full bladder. Medication may be taken with water.
☐ **Pelvis:**	Prostate, bladder (Pre/Post void) seminal vesicles, RLQ, LLQ - May eat and must drink 40 oz of water finishing 1 hour prior to arrival. Arrive with a full bladder.
☐ **Pelvis** ☐ **Transvaginal:**	Bladder, uterus, endometrium, ovaries, adnexa, RLQ, LLQ - May eat and must drink 40 oz of water finishing 1 hour prior to arrival. Arrive with a full bladder.
☐ **Pregnancy (early 6-12 weeks):**	May eat and must drink 40 oz of water finishing 1 hour to arrival. Arrive with a full bladder.

No preparation needed for the following:

☐ **Appendix** ☐ **Abdominal Wall Hernia** ☐ **Inguinal Canal**

☐ **Thyroid** ☐ **Neck** ☐ **Carotids** ☐ **Scrotum** ☐ **Extremity (Nodule)**

☐ **Venous Doppler Circle one: Left Right** ☐ **MSK of _____**

Mandatory Clinical History (Reason for Request):

Referring Physician: _____ Physician's Signature: _____ Date: _____
(Please Print) (Must be signed) (DD/MM/YYYY)

Cc: _____ CPSO #: _____ OHIP Billing #: _____

Technologist's Signature:	Lead Used:
# of images:	Patient Pregnant:

1 KDH is part of the Ontario Breast Screening Program. We only do patients with no breast symptoms. Please refer patients with symptoms and any breast ultrasound to another breast centre, such as Winchester.
2 Unable to perform leg length and scoliosis x-rays.