Children's Hospital
London Health Sciences Centre

Children's Ultrasound, Fluoroscopy and General X-Ray Requisition

Fax: 519-667-6826 Phone: 519-685-8770

MRN: _____
Patient Name: _____
Gender: ☐M ☐F ☐T Date of birth: _____
Address: _____
City: _____ Province: _____
Postal code: _____ Home Tel: _____ Cell: _____
OHIP Health Card _____
Parent/guardian: _____ Relationship: _____

AGE

Ultrasound

- ☐ Abdomen
- ☐ Renal
- ☐ Pelvic
- ☐ Groin
- ☐ Scrotum
- ☐ Leg Veins
- ☐ Spine
- ☐ Hips (6 weeks to 6 months)
- ☐ Soft Tissue _____
- ☐ Musculoskeletal _____
- ☐ Hernia _____
- ☐ Other _____
- ☐ Breast (<10 years of age)

For 10-18 years of age, please refer to a LHSC Paediatric surgeon first

- ☐ Head
- ☐ Face
- ☐ Neck
- ☐ Thyroid

General X-Ray

L	R			
☐	☐	Finger	☐	Pelvis and Frog-Leg
☐	☐	Hand	☐	Skull
☐	☐	Wrist	☐	Neck
☐	☐	Forearm	☐	Cervical Spine
☐	☐	Elbow	☐	Thoracic Spine
☐	☐	Humerus	☐	Lumbar Spine
☐	☐	Shoulder	☐	Scoliosis
☐	☐	Clavicle	☐	Chest PA Lateral
☐	☐	Toe	☐	Abdomen 1 view
☐	☐	Foot	☐	Abdomen 2 views
☐	☐	Ankle	☐	KUB
☐	☐	Tibia Fibula	☐	Skeletal Survey_____
☐	☐	Knee	☐	Shunt Series
☐	☐	Femur	☐	Other_____

Fluoroscopy

Gastrointestinal

- ☐ Upper Gastro-intestinal (UGI)
- ☐ Barium Swallow
- ☐ Small Bowel Follow Thru (SBFT)
- ☐ UGI with SBFT
- ☐ Enema Water soluble
- ☐ _____

Genito-Urinary Tract

- ☐ Voiding Cystourethrogram (VCUG)
- ☐ _____

History and Indication for exam (working or known diagnosis, symptoms, clinical findings)

Additional relevant history and comments (previous reaction to contrast, allergies, isolation, cardiac anomaly, special positioning, etc.)

Does the child require any pre-arranged accommodations in order to successfully complete the exam? ☐ No ☐ Yes Details _____
Mobility: ☐Ambulatory ☐Wheelchair ☐Stretcher ☐Mechanical Lift
Preferred Language: ☐English ☐OTHER _____

REFERRING PHYSICIAN:
First Name: _____ Last Name: _____
Address: _____ City: _____
Postal Code: _____ Tel: _____ FAX: _____

Physician's Signature: _____ CPSO No: _____
Copy to: _____

Preferred Date:
_____
We will do our best to accommodate

Urgency

- ☐ Urgent (<2 days)
- ☐ Semi-Urgent (<10 days)
- ☐ Elective

For Emergent (<24 hours) **Please go to your nearest Emergency Department**

OFFICE USE ONLY	FOR MRTs/RADs	FOR BOOKING STAFF
☐ Timed: _____ Staff Initials: _____		Appointment Date: _____ Arrival Time: _____

Incomplete, illegible or inaccurate forms will be returned to you, resulting in a delay in obtaining an appointment.