



**BRANT COMMUNITY HEALTHCARE SYSTEM
X-RAY & INTERVENTIONAL RADIOLOGY REQUISITION**

200 Terrace Hill St., Brantford ON N3R 1G9
 BGH Ph: 519-751-5599 Fax: 519-751-5573
 Willett Ph: 519-442-2251 Fax: 519-442-5172

For Office Use Only: Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION	
Name:	Health Card	Version	DOB
OHIP Billing Number:	First Name:	Last Name:	
Address	Address:		
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:	WSIB Claim #:	Secondary Insurance:	
Copies to:	Patient Height:	Patient Weight:	

Does Patient Require Assistance? Mechanical Lift Wheelchair Language Interpreter - Specify:

BGH X-Ray Hours: Monday to Friday 08:00-19:00, Weekends and Holidays 08:00-15:00

Willett X-Ray Hours Monday to Friday 09:00-20:30, Weekends 10:00-17:30

***Exams at BGH Site Only**

Head and Neck	Upper Extremities	Lower Extremities
<input type="checkbox"/> Adenoids <input type="checkbox"/> Facial Bones <input type="checkbox"/> Mandible <input type="checkbox"/> Mastoids <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Skull <input type="checkbox"/> Soft tissue of Neck <input type="checkbox"/> TMJ's	<input type="checkbox"/> L <input type="checkbox"/> R A.C. Joints <input type="checkbox"/> L <input type="checkbox"/> R Clavicle <input type="checkbox"/> L <input type="checkbox"/> R Elbow <input type="checkbox"/> L <input type="checkbox"/> R Finger <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> L <input type="checkbox"/> R Forearm <input type="checkbox"/> L <input type="checkbox"/> R Hand <input type="checkbox"/> L <input type="checkbox"/> R Humerus <input type="checkbox"/> L <input type="checkbox"/> R Scaphoid <input type="checkbox"/> L <input type="checkbox"/> R Scapula <input type="checkbox"/> L <input type="checkbox"/> R Shoulder <input type="checkbox"/> L <input type="checkbox"/> R Wrist	<input type="checkbox"/> L <input type="checkbox"/> R Ankle <input type="checkbox"/> L <input type="checkbox"/> R Calcaneus <input type="checkbox"/> L <input type="checkbox"/> R Femur <input type="checkbox"/> L <input type="checkbox"/> R Foot <input type="checkbox"/> L <input type="checkbox"/> R Hip <input type="checkbox"/> L <input type="checkbox"/> R Knee <input type="checkbox"/> L <input type="checkbox"/> R Tibia/Fibula <input type="checkbox"/> L <input type="checkbox"/> R Toe <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Orthoroentgenogram (leg length)*
Chest	Spine and Pelvis	Gastric Studies (Appointment Required)
<input type="checkbox"/> Chest (PA/LAT) <input type="checkbox"/> Ribs <input type="checkbox"/> Sternum <input type="checkbox"/> Sternoclavicular Joints	<input type="checkbox"/> Cervical <input type="checkbox"/> Dorsal/Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum and Coccyx <input type="checkbox"/> Sacroiliac Joints <input type="checkbox"/> Scoliosis * <input type="checkbox"/> AP Pelvis	<input type="checkbox"/> Barium Enema * <input type="checkbox"/> Barium Swallow * <input type="checkbox"/> Small Bowel (SBFT) * <input type="checkbox"/> Upper GI *
Abdomen		
<input type="checkbox"/> KUB (1 view) <input type="checkbox"/> Acute (3 views)		

CLINICAL HISTORY: REASON FOR ORDER

Previous Surgeries:

Related Previous Imaging: Yes No **If yes, Where:** **Please attach previous if not completed at BGH.**

Please include all relevant patient history including previous reports or consult notes as appropriate.