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MyHealth | CENTRE

REQUEST FOR EXAMINATION FORM

Healthcare Provider Type: ☐ GP ☐ Specialist ☐ NP ☐ Chiropractor ☐ Physiotherapist ☐ Other: _____

PATIENT INFORMATION (Paste Patient Label, if Available)

Check if Applicable ☐ URGENT

Patient Full Name: _____

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Phone: _____

Date of Birth: _____ Health Card #: _____

Patient Height (cm): _____ Weight (kg): _____

Clinical Information/Indications:

LONDON SPECIALTY SERVICES

☐ 1055 Fanshawe Park Road West, Suite 301
Tel: 519-439-5555 | Fax: 519-266-2206

LONDON INTERVENTIONAL PROCEDURES

☐ 279 Wharncliffe Road North, Suite 111
Tel: 519-661-0275 | Fax: 519-661-0616

WOMEN'S HEALTH

GENERAL GYNECOLOGY

- ☐ Advanced Contraception
- ☐ Abnormal Uterine Bleeding/Post Menopausal Bleeding
- ☐ Alternatives to Hysterectomy
- ☐ Endometriosis
- ☐ HRT/Bioidentical HRT
- ☐ IUD Insertion & Monitoring
- ☐ Management of Menopause
- ☐ Management of Menstrual Disorders
- ☐ Management of Ovarian Cysts
- ☐ Minimally Invasive Surgery
- ☐ Pap Smear
- ☐ PCOS (Management & Investigation)
- ☐ Uterine Fibroids, Polyps, Septum
- ☐ Other: _____

FERTILITY DIAGNOSIS & TREATMENT

- ☐ Advanced Semen Analysis
- ☐ Fertility Consultation
- ☐ Fertility Preservation (Egg Freezing, Sperm Freezing)
- ☐ Infertility Investigation & Cycle Monitoring
- ☐ Intrauterine Insemination
- ☐ In Vitro Fertilization (IVF)
- ☐ Non-Invasive Prenatal Testing (NIPT)
- ☐ Preimplantation Genetic Screening (PGS)
- ☐ Sonohysterogram +/- Tubal Patency Testing
- ☐ Other: _____

STAMP OFFICE LABEL (IF AVAILABLE)

Referring Physician: _____ (Print Name) _____ (Signature)

OHIP Billing Code: _____ Prof. Reg. #: _____

Fax #: _____

Date: _____

Copy to: _____

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

PARAVERTEBRAL NERVE BLOCK

R	L			
☐	☐	Cervical	☐ Levels _____	☐ Repeat q _____ months
☐	☐	Thoracic	☐ Levels _____	☐ Repeat q _____ months
☐	☐	Lumbar	☐ Levels _____	☐ Repeat q _____ months

*MAXIMUM OF 8 INJECTIONS PER VISIT *MINIMUM OF 2 CONTIGUOUS IPSILATERAL LEVELS

NB: For each two **LUMBAR/THORACIC/CERVICAL** facet levels, patients require a prescription for 1 cc of Celestone Soluspan® and 4 cc of 0.5% Marcaine®. (E.G. a 4 joint lumbar facet injection would require a script for 2 ccs of of Celestone and 8 ccs of Marcaine®).

NB: Patients should fill their prescriptions and bring their medications to the appointment.

THERAPEUTIC JOINT/BURSA INJECTION/ARTHOGRAM

Shoulder

R	L		
☐	☐	Glenohumeral Joint	☐ Repeat q _____ months
☐	☐	Acromioclavicular Joint/Subacromial Bursa	☐ Repeat q _____ months

Wrist

R	L		
☐	☐	Radiocarpal Joint	☐ Repeat q _____ months

Hand

R	L			
☐	☐	Carpometacarpal Joint	Finger: 1 2 3 4 5	☐ Repeat q _____ months
☐	☐	Metacarpophalangeal Joint	Finger: 1 2 3 4 5	☐ Repeat q _____ months

Pelvis

R	L		
☐	☐	Sacroiliac Joint	☐ Repeat q _____ months
☐	☐	Femoroacetabular Joint	☐ Repeat q _____ months
☐	☐	Gr. Trochanteric Bursa	☐ Repeat q _____ months
☐	☐	Iliolumbar Ligament	☐ Repeat q _____ months

Knee

R	L		
☐	☐	Knee	☐ Repeat q _____ months

Ankle

R	L		
☐	☐	Subtalar Joint	☐ Repeat q _____ months
☐	☐	Tibiotalar Joint	☐ Repeat q _____ months

Foot

R	L		
☐	☐	Tarsometatarsal Joint	☐ Repeat q _____ months

Inidcate which tarsal bone: _____

FOR OTHER SITES/PROCEDURES, PLEASE CONTACT DR. BENNETT DIRECTLY:

R	L		
☐	☐	_____	☐ Repeat q _____ months

*MAXIMUM OF 6 INJECTIONS PER VISIT

NB: For each joint / bursa injection patients require a prescription for 1 cc of Celestone Soluspan and 4 ccs of 0.5% Marcaine®.

NB: Patients should fill their prescriptions and bring their medications to the appointment.

LUMBAR EPIDURAL

☐ Lumbar Epidural ☐ Repeat q _____ months

*MUST HAVE A DRIVER

80mg Depomedrol and 10 cc Xylocaine 1 % (without preservative).

NB: Patients should fill their prescriptions and bring their medications to the appointment.

Patient must be taken off ALL blood thinners (e.g. Eliquis/Coumadin/Plavix) other than Aspirin. DISCONTINUE according to recommendations of Thrombosis Canada for neuraxial anesthesia. www.thrombosiscanada.ca/clinicalguides/# *(see reverse)*

Please see the back of this form for locations and details.

v12-12-2018

Please note, all diagnostic tests require a scheduled appointment, except for X-ray (walk-ins accepted).
Now you can take a picture of this form and **TEXT** it to MyHealth Centre: **647-362-9246**

LONDON FANSHAWE	LONDON WHARNCLIFFE
1055 Fanshawe Park Road West, Suite 301 London, ON N6G 5B4 North London Medical Centre on Fanshawe just east of Hyde Park Road **T: 519-439-5555 | F: 519-266-2206** **SERVICES:** BMD, IPS/eFTS, Mammography, Nuclear Cardiology, Pain Injection/Management, Sonohysterogram, Ultrasound, Vascular US, Women's Health, X-ray	279 Wharncliffe Road North, Suite 111 London, ON N6H 2C2 Wharncliffe Health Centre, north of Oxford Street **T: 519-661-0275 | F: 519-661-0616** **SERVICES:** BMD, Holter, IPS/eFTS, Mammography & OBSP, Pain Injection/Management, Thyroid FNA Biopsy, Ultrasound, Vascular US, X-ray **For Lumbar Epidural guidelines, please ask for a pamphlet**.

For test preparations in 15+ languages, please visit MyHealthCentre.ca/Locations or call 416-223-5460

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This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx