

SOUTHWESTERN ONTARIO

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Arva | <input type="checkbox"/> Brantford | <input type="checkbox"/> Delhi | <input type="checkbox"/> London Fanshawe |
| <input type="checkbox"/> London Southdale | <input type="checkbox"/> London Waterloo | <input type="checkbox"/> London Wharnccliffe | <input type="checkbox"/> Simcoe |

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

Check if Applicable **URGENT**

PATIENT INFORMATION (Paste Patient Label, if Available)

Patient Full Name: _____
 Address: _____
 City: _____ Prov.: _____ Postal Code: _____ Phone: _____
 Date of Birth: _____ Health Card #: _____
 Patient Height (cm): _____ Weight (kg): _____
 Clinical Information/Indications: _____

CARDIOLOGY

- | | |
|--|--|
| <input type="checkbox"/> 12-Lead Electrocardiogram (Rest ECG) | <input type="checkbox"/> Echocardiogram (Colour Doppler) |
| <input type="checkbox"/> Exercise Stress Test (GXT) | Select one of the following indications: |
| <input type="checkbox"/> Holter Monitoring | <input type="radio"/> Chest pain suspicious of CAD |
| <input type="radio"/> 24 hrs <input type="radio"/> 48 hrs <input type="radio"/> 72 hrs | <input type="radio"/> Congestive heart failure |
| <input type="radio"/> Other: _____ | <input type="radio"/> Palpitations/arrhythmias |
| <input type="checkbox"/> Loop/Cardiac Event Monitoring | <input type="radio"/> Murmur |
| <input type="checkbox"/> 24hr BP Monitor (\$80.00 fee required) | <input type="radio"/> Hypertension |
| <input type="checkbox"/> Cardio-Pulmonary Testing - Simcoe | <input type="radio"/> Syncope |
| <input type="radio"/> Pre & Post Spirometry | <input type="radio"/> Other: _____ |
| <input type="radio"/> Full Pulmonary Function Test | <input type="checkbox"/> Contrast Echocardiogram |
| <input type="radio"/> Include Respirology Consult | |

CARDIOLOGY CONSULTATION

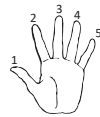
- Urgent First Available Consult if Test Result is Positive/Abnormal
 Dr. _____

NUCLEAR CARDIOLOGY

- | | | |
|-------------------------------------|---|---|
| Myocardial Perfusion | Myocardial Viability | Ventricular Function |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Viability Study (Thallium) | <input type="checkbox"/> Resting (MUGA) - Simcoe |
| <input type="checkbox"/> Persantine | | |
| <input type="checkbox"/> Dobutamine | | |

X-RAY (WALK-INS ACCEPTED)

- | | | |
|--|---|--|
| ABDOMINAL | LOWER EXTREMITIES | UPPER EXTREMITIES |
| <input type="checkbox"/> Single/KUB | R L | R L |
| <input type="checkbox"/> Acute (includes PA chest) | <input type="checkbox"/> Hip | <input type="checkbox"/> Shoulder |
| CHEST | <input type="checkbox"/> Femur | <input type="checkbox"/> Clavicle |
| <input type="checkbox"/> Chest PA & LAT | <input type="checkbox"/> Knee | <input type="checkbox"/> Sternoclavicular joints |
| <input type="checkbox"/> Ribs <input type="radio"/> OR <input type="radio"/> L | <input type="checkbox"/> Tib. & Fib. | <input type="checkbox"/> A.C. Joint |
| <input type="checkbox"/> Sternum | <input type="checkbox"/> Ankle | <input type="checkbox"/> Scapula |
| <input type="checkbox"/> Chest Visa | <input type="checkbox"/> Foot | <input type="checkbox"/> Humerus |
| HEAD & NECK | <input type="checkbox"/> Heel | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Toe: 1 2 3 4 5 | <input type="checkbox"/> Forearm |
| <input type="checkbox"/> Skull | SPINE & PELVIS | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Scaphoid |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Hand |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Lumbar (L/S) Spine | <input type="checkbox"/> Finger: 1 2 3 4 5 |
| <input type="checkbox"/> Mandible | <input type="checkbox"/> Sacrum/Coccyx | <input type="checkbox"/> SKELETAL SURVEY |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> S.I. Joints | <input type="radio"/> Bone Age |
| <input type="checkbox"/> T.M. Joints | <input type="checkbox"/> Pelvis | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Adenoids | | |
| <input type="checkbox"/> Mastoids | | |



ULTRASOUND

GENERAL ULTRASOUND

- Abdomen
 Abdomen + Pelvic + Transvaginal
 Abdomen + Pelvic Limited
 Renal
 Bladder

PELVIS

- Female Pelvic
 Transvaginal Transrectal
 Male Pelvic
 Prostate/Transrectal

OBSTETRICAL

- Dating < 16 weeks
 NT 11 - 14 weeks (IPS/eFTS)
 Anatomic 18 - 20 weeks
 Combined NT (IPS/eFTS) + Anatomic

- Fetal growth follow-up
 Biophysical Profile (BPP)
 Twin Series
 Follicular Studies

SMALL PARTS

- Face
 Thyroid and Neck
 Neck
 Breast R L
 Chest
 Groin R L
 Testes/Scrotum
 Soft Tissue/Lump

MUSCULOSKELETAL

- R L**
 Shoulder
 Rotator Cuff
 Elbow
 Wrist
 Hip
 Hamstring
 Knee
 Popliteal Fossa
 Ankle
 Achilles Tendon
 Plantar Fascia
 Other: _____

US GUIDED PROCEDURES

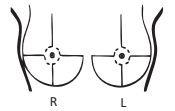
- Sonohysterogram - **London Fanshawe**
 Thyroid FNA Biopsy - **London Wharnccliffe**

VASCULAR

- R L**
 Carotid
 Renal Arteries
 Aorta
 Portal Venous Doppler
 Venous - Lower Extremity (DVT)
 Venous - Lower Extremity (Reflux)
 Venous - Upper Extremity (DVT)
 Arterial - Lower Extremity (ABI)
 Arterial - Upper Extremity
 OTHER: _____

MAMMOGRAPHY & BONE MINERAL DENSITY

- Mammogram R L Implants
 Ontario Breast Screening Program (OBSP) 50-74



BONE MINERAL DENSITY

- Baseline Study Follow Up High Risk

NUCLEAR MEDICINE - SIMCOE

BONE SCAN

- Total Body
 Specific Site: _____
 SPECT

GALLIUM

- Total Body
 Specific Site: _____
 SPECT

GASTROINTESTINAL

- Gallbladder/Biliary Scan
 Gastric Emptying Scan
 Liver/Spleen Scan
 Hemangioma Scan
 G.I. Bleeding Scan
 Meckel's Scan

ENDOCRINE

- Thyroid Scan Only
 Thyroid Uptake & Scan
 Parathyroid

Indication for ordering thyroid scan:

- Hyperthyroidism
 Other: _____

RENAL

- Captopril Renal
 Lasix Renal
 Renal Function (Baseline)

MISCELLANEOUS

- V/Q Lung Scan
 Salivary Scan
 Sentinel Node Scan

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: _____

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

ARVA 21589 Richmond Street Arva, ON N0M 1C0 Richmond Street, north of the London Masonville Mall T: 519-672-0070 F: 519-850-0144 SERVICES: Cardiology, Cardiology Consultation, IPS/eFTS, Ultrasound	BRANTFORD 40 Shellington Place, Suite 101 Brantford, ON N3S 0C5 Brantford Medical Centre off Highway 403, Garden Avenue/Cainsville exit T: 519-805-3560 F: 519-805-3561 SERVICES: Cardiology, Cardiology Consultation
DELHI 105 Main Street Delhi, ON N4B 2L8 Delhi Community Health Centre on Main Street, north of King Street T: 519-428-1243 F: 519-428-2445 SERVICES: Ultrasound, Vascular US	LONDON FANSHAWE 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
LONDON SOUTHDALÉ 510 Southdale Road East, Suite 103 London, ON N6E 0B2 Nixon Medical Centre at the corner of Nixon and Southdale Road T: 226-663-2933 F: 226-663-4561 SERVICES: IPS/eFTS, Ultrasound, X-ray	LONDON WATERLOO 111 Waterloo Street, Suite 100 London, ON N6B 2M5 Victoria Professional Centre at the corner of Waterloo and Hill Street T: 519-432-3715 F: 519-432-1980 SERVICES: IPS/eFTS, Ultrasound, Vascular US, X-ray
LONDON WHARNCLIFFE 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	SIMCOE 216 West Street, Suite 304 Simcoe, ON N3Y 1S8 West Street Health Centre at the corner of Queen and West Street T: 519-428-1243 F: 519-428-2445 SERVICES: BMD, Cardiology, Cardiology Consultation, IPS/eFTS, Nuclear Cardiology, Nuclear Medicine, Pulmonary Function, Ultrasound, Vascular US, X-ray

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



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>