

**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)                                    | <b>Select one of the following indications:</b>          |
| <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 - <b>Simcoe</b>                      | <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**

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

**X-RAY (WALK-INS ACCEPTED)**

- |  |   |  |
|--|---|--|
| <b>ABDOMINAL</b>   | <b>LOWER EXTREMITIES</b>                    | <b>UPPER EXTREMITIES</b>                         |
| <input type="checkbox"/> Single/KUB  | <b>R L</b>                                  | <b>R L</b>                                       |
| <input type="checkbox"/> Acute (includes PA chest)                             | <input type="checkbox"/> Hip                | <input type="checkbox"/> Shoulder                |
| <b>CHEST</b>   | <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                 |
| <b>HEAD &amp; NECK</b>   | <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   | <b>SPINE &amp; PELVIS</b>                   | <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"/> <b>SKELETAL SURVEY</b>  |
| <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"/> <b>OTHER:</b> _____     |
| <input type="checkbox"/> Adenoids  |   |  |
| <input type="checkbox"/> Mastoids  |   |  |



**ULTRASOUND**

**GENERAL ULTRASOUND**

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

**PELVIS**

- Female Pelvis  Transvaginal  Transrectal  Male Pelvis  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**

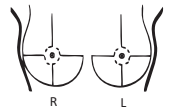
- Sonohysterogram - **London Fanshawe**  Thyroid FNA Biopsy - **London Wharnccliffe**

**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

**ENDOCRINE**

- Thyroid Scan Only  Thyroid Uptake & Scan  Parathyroid

**GALLIUM**

- Total Body  Specific Site: \_\_\_\_\_  SPECT

**Indication for ordering thyroid scan:**

- Hyperthyroidism  Other: \_\_\_\_\_

**GASTROINTESTINAL**

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

**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

<b>ARVA</b> 21589 Richmond Street Arva, ON N0M 1C0 Richmond Street, north of the London Masonville Mall <b>T: 519-672-0070   F: 519-850-0144</b> <b>SERVICES:</b> Cardiology, Cardiology Consultation, IPS/eFTS, Ultrasound	<b>BRANTFORD</b> 40 Shellington Place, Suite 101 Brantford, ON N3S 0C5 Brantford Medical Centre off Highway 403, Garden Avenue/Cainsville exit <b>T: 519-805-3560   F: 519-805-3561</b> <b>SERVICES:</b> Cardiology, Cardiology Consultation
<b>DELHI</b> 105 Main Street Delhi, ON N4B 2L8 Delhi Community Health Centre on Main Street, north of King Street <b>T: 519-428-1243   F: 519-428-2445</b> <b>SERVICES:</b> Ultrasound, Vascular US	<b>LONDON FANSHAWE</b> 1055 Fanshawe Park Road West, Suite 301 London, ON N6G 5B4 North London Medical Centre on Fanshawe just east of Hyde Park Road <b>T: 519-439-5555   F: 519-266-2206</b> <b>SERVICES:</b> BMD, IPS/eFTS, Mammography, Nuclear Cardiology, Pain Injection/Management, Sonohysterogram, Ultrasound, Vascular US, Women's Health, X-ray
<b>LONDON SOUTHDALÉ</b> 510 Southdale Road East, Suite 103 London, ON N6E 0B2 Nixon Medical Centre at the corner of Nixon and Southdale Road <b>T: 226-663-2933   F: 226-663-4561</b> <b>SERVICES:</b> IPS/eFTS, Ultrasound, X-ray	<b>LONDON WATERLOO</b> 111 Waterloo Street, Suite 100 London, ON N6B 2M5 Victoria Professional Centre at the corner of Waterloo and Hill Street <b>T: 519-432-3715   F: 519-432-1980</b> <b>SERVICES:</b> IPS/eFTS, Ultrasound, Vascular US, X-ray
<b>LONDON WHARNCLIFFE</b> 279 Wharncliffe Road North, Suite 111 London, ON N6H 2C2 Wharncliffe Health Centre, north of Oxford Street <b>T: 519-661-0275   F: 519-661-0616</b> <b>SERVICES:</b> BMD, Holter, IPS/eFTS, Mammography & OBSP, Pain Injection/Management, Thyroid FNA Biopsy, Ultrasound, Vascular US, X-ray	<b>SIMCOE</b> 216 West Street, Suite 304 Simcoe, ON N3Y 1S8 West Street Health Centre at the corner of Queen and West Street <b>T: 519-428-1243   F: 519-428-2445</b> <b>SERVICES:</b> 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](http://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>