

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 #: \_\_\_\_\_  
 Gender: \_\_\_\_\_ 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 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
- Indicate 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/#](http://www.thrombosiscanada.ca/clinicalguides/#) (see reverse)

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: 647-694-7800

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

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>