

REQUEST FOR EXAMINATION – X-RAY SERVICES FOR CHIROPRACTORS

- | | | | | | |
|------------------------------------------|-------------------------------------------|---------------------------------------------|-------------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> London Fanshawe | <input type="checkbox"/> London Southdale | <input type="checkbox"/> London Wharncliffe | <input type="checkbox"/> Milton | <input type="checkbox"/> Mississauga | <input type="checkbox"/> Newmarket |
| <input type="checkbox"/> North York | <input type="checkbox"/> Pickering | <input type="checkbox"/> Sarnia | <input type="checkbox"/> Sault Ste. Marie | <input type="checkbox"/> Scarborough | <input type="checkbox"/> Simcoe |
| <input type="checkbox"/> Sudbury Larch | <input type="checkbox"/> Sudbury Lasalle | <input type="checkbox"/> Sudbury Long Lake | <input type="checkbox"/> Thornhill | <input type="checkbox"/> Toronto Bay | <input type="checkbox"/> Toronto King |

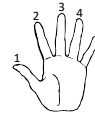
PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Full Name (Birth): _____
 Preferred Full Name (If Different from Birth): _____
 Address: _____
 City: _____ Prov.: _____ Postal Code: _____
 Cell Phone: _____ Alt. Phone: _____
 Date of Birth: _____
 Health Card #: _____ Version: _____
 Gender: _____ Preferred Gender (If Different from Birth): _____
 Height (cm): _____ Weight (kg): _____

Reason for Referral: _____ Report Required (Fee May Apply)

X-RAY (WALK-IN SERVICE)

- | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>CHEST</p> <p><input type="checkbox"/> Ribs OR <input type="checkbox"/> OL
 <input type="checkbox"/> Sternum</p> <p>HEAD & NECK</p> <p><input type="checkbox"/> Soft Tissue Neck
 <input type="checkbox"/> Skull
 <input type="checkbox"/> Sinuses
 (Not insured by OHIP)
 <input type="checkbox"/> Facial Bones
 <input type="checkbox"/> Nose
 <input type="checkbox"/> Mandible
 <input type="checkbox"/> Orbits
 <input type="checkbox"/> T.M. Joints
 <input type="checkbox"/> Adenoids</p> | <p>SPINE & PELVIS</p> <p><input type="checkbox"/> Cervical Spine
 <input type="checkbox"/> Thoracic Spine
 <input type="checkbox"/> Lumbar (L/S) Spine
 <input type="checkbox"/> Sacrum/Coccyx
 <input type="checkbox"/> S.I. Joints
 <input type="checkbox"/> Pelvis
 <input type="checkbox"/> Scoliosis Series</p> | <p>LOWER EXTREMITIES</p> <p>R L</p> <p><input type="checkbox"/> Hip
 <input type="checkbox"/> Femur
 <input type="checkbox"/> Knee
 <input type="checkbox"/> Tib. & Fib.
 <input type="checkbox"/> Ankle
 <input type="checkbox"/> Foot
 <input type="checkbox"/> Calcaneus
 <input type="checkbox"/> Toe: 1 2 3 4 5</p> | <p>UPPER EXTREMITIES</p> <p>R L</p> <p><input type="checkbox"/> Shoulder
 <input type="checkbox"/> Clavicle
 <input type="checkbox"/> Sternoclavicular Joints
 <input type="checkbox"/> A.C. Joint
 <input type="checkbox"/> Scapula
 <input type="checkbox"/> Humerus
 <input type="checkbox"/> Elbow
 <input type="checkbox"/> Forearm
 <input type="checkbox"/> Wrist
 <input type="checkbox"/> Scaphoid
 <input type="checkbox"/> Hand
 <input type="checkbox"/> Finger: 1 2 3 4 5</p> | <p>OTHER</p> <p><input type="checkbox"/> Leg Lengths
 <input type="checkbox"/> Skeletal Survey
 <input type="checkbox"/> Indicate: _____</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|



REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)

Referring Provider: _____ (Print Name) _____ (Signature)
 Billing Provider #: _____ CCO #: _____
 Tel #: _____ Fax #: _____
 Date: _____ Copy To: _____
 Report Delivery Preference: Fax HRM Other: _____

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<p>LONDON FANSHAWE</p> <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>T: 519-439-5555 F: 519-266-2206 E: london_fanshawe@welldiagnostics.ca</p>	<p>LONDON SOUTHDALE</p> <p>510 Southdale Road East, Suite 103 London, ON N6E 0B2 Nixon Medical Centre at the corner of Nixon and Southdale Road</p> <p>T: 226-663-2933 F: 226-663-4561 E: london_southdale@welldiagnostics.ca</p>	<p>LONDON WHARNCLIFFE (RADIOLOGY)</p> <p>279 Wharncliffe Road North, Suite 111 London, ON N6H 2C2 Wharncliffe Health Centre, north of Oxford Street</p> <p>T: 519-661-0275 F: 519-661-0616 E: london_wharncliffe_radiology@welldiagnostics.ca</p>
<p>MILTON (RADIOLOGY)</p> <p>480 Bronte Street South, Suite 212 Milton, ON L9T 9A9 Milton Professional Centre, north of Derry Road</p> <p>T: 905-878-8831 F: 1-800-249-6284 E: milton_radiology@welldiagnostics.ca</p>	<p>MISSISSAUGA (RADIOLOGY)</p> <p>2300 Eglinton Avenue West, Suite G02 Mississauga, ON L5M 2V8 Credit Valley Professional Building, beside hospital</p> <p>T: 905-828-0653 F: 905-828-0765 E: mississauga_radiology@welldiagnostics.ca</p>	<p>NEWMARKET (RADIOLOGY)</p> <p>17730 Leslie Street, Suite 106 Newmarket, ON L3Y 3E4 North of Davis Drive in the York Medical Health Centre</p> <p>T: 905-836-2626 F: 905-836-5043 E: newmarket_radiology@welldiagnostics.ca</p>
<p>NORTH YORK</p> <p>4949 Bathurst Street, Suite 100 North York, ON M2R 1Y1 Northview Centre at Bathurst and Finch</p> <p>T: 416-223-5460 F: 416-223-8335 E: northyork@welldiagnostics.ca</p>	<p>PICKERING</p> <p>1105 Kingston Road, Building D, Suite 202 Pickering, ON L1V 1B5 Brookdale Centre, behind Shoppers Drug Mart, 2nd Fl.</p> <p>T: 905-420-3068 F: 905-420-6057 E: pickering@welldiagnostics.ca</p>	<p>SARNIA</p> <p>481 London Road, Suite B-101 Sarnia, ON N7T 4X3 Beside Bluewater Health at Norman and London</p> <p>T: 519-336-8110 F: 1-800-507-3880 E: sarnia@welldiagnostics.ca</p>
<p>SAULT STE. MARIE</p> <p>955 Queen Street East, Suite 50 Sault Ste. Marie, ON P6A 2C3 The Doctor's Building between the two hospitals</p> <p>T: 705-759-1144 F: 705-759-5978 E: ssm_queen@welldiagnostics.ca</p>	<p>SCARBOROUGH</p> <p>462 Birchmount Road, Unit 1B Scarborough, ON M1K 1N8 Birchmount Plaza, near Dollarama and Pharmasave</p> <p>T: 416-690-9437 F: 416-690-9441 E: scarborough@welldiagnostics.ca</p>	<p>SIMCOE</p> <p>216 West Street, Suite 304 Simcoe, ON N3Y 1S8 West Street Health Centre at the corner of Queen and West Street</p> <p>T: 519-428-1243 F: 519-428-2445 E: simcoe@welldiagnostics.ca</p>
<p>SUDBURY LARCH (RADIOLOGY)</p> <p>65 Larch Street, Suite 103 Sudbury, ON P3E 1B8 Larch Medical Building at Larch Street, just east of Durham</p> <p>T: 705-673-2565 F: 705-673-4482 E: sudbury_larch_radiology@welldiagnostics.ca</p>	<p>SUDBURY LASALLE</p> <p>1122 Lasalle Boulevard, Suite 107 Sudbury, ON P3A 1Y4 Balmoral Walk-in Clinic on Lasalle between Carmen and Attlee</p> <p>T: 705-560-1114 F: 705-560-7191 E: sudbury_lasalle@welldiagnostics.ca</p>	<p>SUDBURY LONG LAKE</p> <p>2009 Long Lake Road, Suite B3 Sudbury, ON P3E 6C3 Four Corners Medical Arts Centre next to Shoppers Drug Mart</p> <p>T: 705-523-1295 F: 705-523-2012 E: sudbury_longlake@welldiagnostics.ca</p>
<p>THORNHILL</p> <p>7241 Bathurst Street, Unit 12 Thornhill, ON L4J 3W1 North of Steeles in Chabad Gate Plaza, near Circle K</p> <p>T: 905-889-2400 F: 905-889-2455 E: thornhill@welldiagnostics.ca</p>	<p>TORONTO BAY</p> <p>790 Bay Street, Suite 716 Toronto, ON M5G 1N8 Southwest corner of Bay and College beside CIBC</p> <p>T: 416-260-9382 F: 416-260-2274 E: toronto_bay@welldiagnostics.ca</p>	<p>TORONTO KING</p> <p>11 King Street West, Suite C-100 Toronto, ON M5H 4C7 Yonge and King in the underground PATH</p> <p>T: 416-864-1814 F: 416-864-1499 E: toronto_king@welldiagnostics.ca</p>



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