ST JOSEPH'S HEALTH CENTRE TORONTO

DIAGNOSTIC IMAGING DEPARTMENT
GENERAL X-RAY, ULTRASOUND,
NUCLEAR MEDICINE, FLUOROSCOPY,
MAMMOGRAPHY, BONE MINERAL DENSITOMETRY

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

Name:
Male ☐ Female ☐
MRN :
DOB:
Address:

Telephone:
OHIP #:

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

EXAMINATION(S) REQUESTED: ☐ **STAT/TODAY** ☐ **URGENT** ☐ **ROUTINE** ☐ **PORTABLE**

Location: Ambulatory Other

General X-ray: Ultrasound:

Nuclear Medicine: GI/GU/Fluoroscopy:

Mammography:

Bone Mineral Density: ☐ High Risk ☐ Low Risk ☐ Baseline

Current Patient Location: ☐ Outpatient ☐ Clinic/ACC ☐ Emergency ☐ Inpatient

Study to be Done as: ☐ Outpatient ☐ Inpatient

WSIB/Third Party Claim Number: PREFERRED DAYS/TIME (not guaranteed):

CLINICAL HISTORY **Isolation Precautions:** ☐ **N/A** ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Reverse**

(For Emergency Ultrasound Patients: Specify Date of Follow-up:)

ADDITIONAL INFORMATION

EDC or date of Last Menstrual Period: ☐ **(Required for Obstetrical patients)**

☐ Falls Risk ☐ Lifting Device Required ☐ Patient with Restraints (must be accompanied)

Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No

Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No

Contact Telephone Number (if different from above):

REQUESTING PHYSICIAN

Address: City: Postal Code:

Telephone Number: Fax:

Copy to: MD (Physician's Printed Name)

DATE	**SIGNATURE**	**PRINT NAME**
DD / Month / YYYY		