St. Joseph's Hospital
Medical Imaging Program
268 Grosvenor St., PO Box 5777, Stn. B
London, ON N6A 4V2
Tel. 519-646-6044

# Radiology Referral Form

**Fax to 519-646-6204**

**NOTE:** Medical Imaging (MI) does not **accept walk-in** general x-ray patients. All general x-rays MUST be booked by **faxed requisition to 519-646-6204** or by **calling MI Bookings, 519-646-6000 ext. 65074**. For same-day exams, call Bookings at (519) 646-6000 ext. 65074 **before sending the patient to imaging**, to determine if request can be accommodated**.**

## *1.* Patient information

Last name: _____ First Name: _____ Middle Initial: _____

Gender: M F Date of birth (YYYY/MM/DD): _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alternate Phone: _____

Health card number: _____ Version Code: _____

WCB Employer: _____ S.I.N.# _____ ACCIDENT DATE: _____ (YYYY/MM/DD)

**Preferred language** ☐ English ☐Other: _____ Interpreter required? ☐ No ☐ Yes

**Mobility** ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Portable ☐ Mechanical lift required

**Diabetes** ☐ No ☐ Yes **Pregnant** ☐ No ☐ Unknown ☐ Yes, _____weeks

**Research study?** ☐ No ☐ Yes Study#: _____ Study name:_____

## *2.* Allergies: ☐ None ☐ **If patient has known latex or contrast allergy, please notify us as soon as possible at 519-646-6044**

## *3.* Previous exams ☐ None

| | | | | | |
|---|---|---|---|---|---|
| ☐ X-Ray | **at** | ☐ St. Joseph's Health Care London | ☐ LHSC | ☐ Other: | _____ |
| ☐ Nuclear Medicine | **at** | ☐ St. Joseph's Health Care London | ☐ LHSC | ☐ Other: | _____ |
| ☐ Ultrasound | **at** | ☐ St. Joseph's Health Care London | ☐ LHSC | ☐ Other: | _____ |

## *4.* Exam requested:

*NOTE: Bone Mineral Density (BMD) exams should be submitted on the BMD referral form available at www.sjhc.london.on.ca*

☐ **X-ray** ☐ **Injection** ☐ **Other**: _____

☐ **Fluoroscopy:** ☐ Barium swallow ☐ Upper GI series ☐ Small bowel follow through

☐ Site: _____ → Side: ☐ Right side ☐ Left side

**Diagnosis suspected**: _____

**Clinical Findings and History:** _____

## *5.* Referring Health Care Provider

Last name: _____ First Name: _____ **Signature**: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Fax: _____ OHIP Billing Number: _____

Copy to: _____ Fax _____

**Radiology department use only:** ☐ Emergency ☐ Urgent ☐ Elective ☐ Research Appointment date: _____