St. Joseph's Hospital
Diagnostic Imaging Centre, Room Co-200
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: X-ray/Radiographic exams **do not** require a booked appointment. Send patient with requisition Monday-Friday, 7:00 am-3:30 pm. Faxed requisitions will be kept on file at the Diagnostic Imaging reception desk.

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

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: _____

☐ Nuc Med **at** ☐ St. Joseph's Health Care London ☐ LHSC ☐ Other: _____

☐ Ultrasound **at** ☐ St. Joseph's Health Care London ☐ LHSC ☐ Other: _____

4. Exam requested: ☐ X-ray ☐ Injection ☐ Other: _____

→ Site: _____ → ☐ 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 Dept. use only: ☐ Emergency ☐ Urgent ☐ Elective ☐ Research Appointment date: _____

Revised: Nov. 2019