Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

Fax: 613-548-2413
Tel: 613-548-2301
www.kgh.on.ca

Fax: 613-544-6505
Tel: 613-544-3400 ext. 3020
www.hoteldieu.com

IMAGING SERVICES REQUISITION

GENERAL RADIOLOGY, ULTRASOUND & NUCLEAR MEDICINE

Do Not Use For Breast Imaging

INPATIENT ☐ Service: ____________________

Floor ____________ Room # ________ ER ____________

☐ Portable ☐ Stretcher ☐ Wheelchair ☐ Walk ☐ O_2

Isolation: ☐ No ☐ Yes/type ____________________

OUTPATIENT ☐

☐ Clinic ☐ CCSEO ☐ ER/UCC ☐ Other ____________

Isolation: ☐ No ☐ Yes/type ____________________

Consultation only: ☐ Research: ☐

Department of Veterans Affairs ID # ____________

WSIB #: ____________ Injury Date ____________

Employer: ____________________

Employer Address: ____________________

CR#:: ____________ ☐ Female ☐ Male

Surname: ____________________

First Name: ____________________

Date of Birth: ____________________

Address: ____________________

Phone #: (H) ____________ (W) ____________

Health Card # ____________________

PLEASE WRITE OR PRINT LEGIBLY

INCOMPLETE or ILLEGIBLE requisitions will be returned and may DELAY Study

Examination Requested

Study Type: ☐ X-ray ☐ Ultrasound ☐ Nuclear Medicine

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Previous films/location: ____________________

Adverse Reaction: ☐ Yes/type ____________ ☐ No

LMP(YYYY/MM/DD) ____________________

Is patient able to give informed consent ☐ No ☐ Yes

Diabetes ☐ No ☐ Yes - If yes, Insulin Dependent ☐ No ☐ Yes

Clinical History/Diagnosis

____

____

____

____

____

Ordering Physician Signature: ____________________

Printed Name & First Initial: ____________________

Ordering Physician phone/pager #: ____________________

Attending Physician: ____________________

Copy Report to: ____________________
(please print name and first initial)

Date requisition complete ____________________
YYYY/MM/DD

Ultrasound – Instructions for Imaging Use Only	**Nuclear Medicine – Instructions for Imaging Use Only**
Priority/Protocol ____________________	Coding: ____________________
Signature of Radiologist/Resident:	