

**WEST HALDIMAND GENERAL HOSPITAL**

75 Parkview Rd., Hagersville, Ontario N0A 1H0

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**DIAGNOSTIC IMAGING DEPARTMENT**

OUT-PATIENT    IN-PATIENT    ISOLATION

U# \_\_\_\_\_

PATIENT'S LAST NAME	FIRST NAME	<input type="checkbox"/> M   IDENTIFIES AS: <input type="checkbox"/> F	BIRTH DATE
ADDRESS		CITY	POSTAL CODE
PATIENTS PHONE #   HOME: _____ CELL PHONE: _____		H.I.N.	VERSION CODE
APPOINTMENT DATE AND TIME			<input type="checkbox"/> STAT <input type="checkbox"/> WSIB

**X-RAY - No Appointment**

**ABDOMEN**

- 1 view
- Acute - 3 views

**HEAD & NECK**

- Neck for Soft Tissues
- Skull
- Facial Bones
- Nose
- Mandible
- T.M. Joints
- Mastoids
- Orbits - MRI

**SPINE & PELVIC**

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Sacrum/Coccyx
- S.I. Joints
- Pelvis    Hip    R    L
- Scoliosis
- CHEST**
- Chest PA & LAT
- Chest Portable
- Ribs    R    L    B
- Sterno - Clavicular Jts.
- Sternum

**UPPER EXTREMITIES**

- R   L
- Clavicle
- A.C. Joints
- Shoulder
- Scapula
- Humerus
- Elbow
- Forearm
- Wrist
- Scaphoid
- Hand
- Digit   1   2   3   4   5
- Bone Age

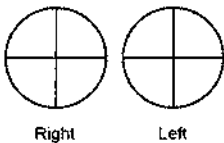


**CARDIO - By Appointment**

- Holter Monitor    24 Hr.    48 Hr.    72 Hr.    14 DAYS
- Electrocardiogram (no appointment needed)

**MAMMOGRAPHY - By Appointment Only**

- Left
- Right
- Bilateral
- OBSP



PREVIOUS

Date \_\_\_\_\_  
Location \_\_\_\_\_

**LOWER EXTREMITIES**

- R   L
- Femur
- Knee
- Patella
- Tib. & Fib.
- Ankle
- Foot
- Toe   1   2   3   4   5
- (Calcaneus) heel
- Leg Length

**ULTRASOUND - By Appointment Only**

- OB U/S for dating (less than 16 weeks)\*
- OB U/S ROUTINE (18-20 weeks)\*
- OB U/S NON ROUTINE\*
- Abdomen\* (includes kidneys, liver, pancreas, gallbladder, spleen, aorta)
- Aorta Only\*
- Kidneys and Bladder\* only
- Female Pelvis (includes uterus, ovaries and bladder)
- Male Pelvis (To include bladder + prostate)
- Scrotal/Testicular
- Breast    R    L    B
- Popliteal Fossa    R    L    B
- Thyroid
- Soft Tissue Neck
- Shoulder    R    L    B
- Knee    R    L    B
- Hernia (no prep)
- Other \_\_\_\_\_

**COLOUR DOPPLER - By Appointment**

- Carotid
- Venous - lower extremity DVT    R    L    B
- Other \_\_\_\_\_

**NOTE: (\*) EXAM REQUIRES PREPARATION - INSTRUCTIONS ON REVERSE →**

Clinical History/Indication for test:

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DOCTOR'S SIGNATURE \_\_\_\_\_

COPY TO \_\_\_\_\_

**TECHNOLOGIST USE ONLY**

Patient states not pregnant

Tech's Initials \_\_\_\_\_

Comments \_\_\_\_\_

IDENTIFICATION  
 D.O.B.    Name    U#