St. Joseph's Hospital
Medical Imaging Centre, Room C0-200
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: Medical Imaging (MI) is **no longer accepting 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 MI Bookings, 519-646-6000 ext. 65074 **before sending the patient to MI**, 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

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: ☐ **X-ray** ☐ **Bone Mineral Density (BMD)** ☐ **Injection** ☐ **Other**: _____

☐ **Fluoroscopy** (by appointment only): ☐ Barium swallow ☐ Upper GI series ☐ Small bowel follow through

☐ Modified Barium Swallow with Speech Language Pathologist (*Pharynx only*)

→ 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: _____

Revised: April 2022