SHN
SCARBOROUGH HEALTH NETWORK

Request for Outpatient Diagnostic Imaging

☐ **BIRCHMOUNT**
3030 Birchmount Road
Scarborough, ON M1W 3W3

☐ **CENTENARY**
2867 Ellesmere Road
Scarborough, ON M1E 4B9

☐ **GENERAL**
3050 Lawrence Ave East
Scarborough, ON M1P 2V5

PHONE 416-431-8167 **FAX** 416-431-8141

Outpatient requests will be given first available at any department unless specified

PATIENT INFORMATION

Name _____ *Last name, First name* Date of birth _____ *Day-Month-Year* Sex ☐ F ☐ M ☐ Other

Health card _____ Version code _____ Hospital ID _____

Address _____

City _____ Postal code _____ Phone 1 _____ *Preferred* Phone 2 _____ *Alternate*

ULTRASOUND

Abdomen	☐ Full abdomen	☐ Renal	☐ Limited specify _____
Pelvis	☐ Female + TVUS	☐ Female w/o TVUS	☐ Male
Obstetrical	☐ 1st trimester LMP _____	☐ Biophysical EDD _____	☐ Other EDD/LMP _____
Small parts	☐ Thyroid	☐ Neck/lymph nodes	☐ Scrotum
MSK	☐ Hip	☐ Knee	☐ Ankle
	☐ Shoulder	☐ Elbow	☐ Wrist
Pediatrics	☐ Head	☐ Spine	☐ Hips
Vascular	☐ Carotids	☐ R ☐ L ☐ Bil Venous lower ext.	☐ R ☐ L ☐ Bil Venous upper ext.
		☐ R ☐ L ☐ Bil Arterial lower ext.	☐ R ☐ L ☐ Bil Arterial upper ext.
Other/biopsy	_____		

GENERAL X-RAY

Specify

FLUOROSCOPY

Gastrics	☐ Barium swallow	☐ Upper GI	☐ Small bowel follow-through
	☐ Barium enema (failed colonoscopy)		
Procedures	☐ Arthrogram/injection	☐ Joint aspiration	☐ Lumbar puncture
	☐ Voiding cystourethrogram	☐ Sinogram	

BONE MINERAL DENSITY

☐ Baseline ☐ Low risk (> 36 months) ☐ High risk (> 12 months)

CLINICAL INDICATION/RELEVANT HISTORY

BILLING

☐ OHIP ☐ WSIB claim # _____ ☐ Other _____

REFERRING PHYSICIAN

Name, address, fax, phone, billing number:

Send copies to:

Signature ✗ _____ Date _____

Incomplete or unsigned requests will be returned and may result in delay