Wentworth-Halton X-Ray and Ultrasound Inc.

Owned and Operated by The Radiologists at Hamilton Health Sciences (Hamilton General Site)

Digital Fax: 905-592-4799 | mskintake@whxray.com | www.whxray.com |

ALL REQUISITIONS must come directly from the referring physician or healthcare provider. **Requisitions will not be accepted directly from patients.**

We ask that all musculoskeletal ultrasound requisitions be faxed to our central scheduling office at **905 592 4799** or scanned and emailed to mskintake@whxray.com. If you are using a custom form in your EMR or are using the OCEANS application just send the requisition as you normally would.

If the need for the exam is related to diagnosing and treating an acute injury, please send the patient to a hospital for this test.

Requisitions will be triaged as quickly as possible after receipt. It may be necessary for Wentworth-Halton X-Ray & Ultrasound to obtain further information from the physcian or health care providers office.

PATIENT INFORMATION

Preferred Location: Medical Arts

Name: _____ Date of Birth: _____

Preferred Name: _____ Health Card Number: _____

Sex (as per OHIP): ☐ Female ☐ Male Identifies As: _____ Phone Number: _____

ULTRASOUND

Ankle	R L
Bicep	R L
Calve/Lower Leg	R L
Elbow	R L
Foot/Toes	R L
Hands/Fingers	R L
Hip	R L
Knee	R L
Thigh	R L
Upper Arm/Forearm	R L
Shoulder	R L
Wrist	R L ☐ Bilateral

Please note that ultrasound is unable to exclude pathology related to menisci, ACL, PCL, cartilage, bone marrow - MRI is required

☐ Anterior Knee Pain (Distal quads, patellar tendon, joint effusion, synoritis)

☐ Posterior Knee Pain (Baker's cyst, poplitcal vessels)

Pain: ☐ Yes ☐ No

Quality:

☐ Burning
☐ Radiating
☐ Shooting
☐ Sharp
☐ Stabbing
☐ Dull
☐ Other: _____

Duration: *days* *months* *years*

Frequency: ☐ Constant ☐ Intermittent

LOCATION

☐ Medial ☐ Lateral ☐ Dorsal
☐ Pantar ☐ Anterior ☐ Posterior
☐ Volar

Paresthesia *(tingling)*

☐ YES **Location:** _____

Clinical Indication, History (reason for exam)

Recent trauma please send requisition to nearest hospital

PRIORITY REPORT

☐ **Request for Stat Case**

Phone: _____

Fax: _____

PRIOR SURGERY: ☐ NO ☐ YES

Describe:

X-RAY WITHIN 3 MONTHS ☐ NO ☐ YES

☐ Relevant X-Ray Ordered. Radiologists initials _____

Referring Physician Signature: X _____ **Date Ordered:** _____

Copies To: _____

Submit Images and Report to:

Healthcare Provider ☐

HNHB MSK-CAIC for Burlington, Hamilton , Stoney Creek& Waterdown ☐

Mississauga Halton Central Intake Program for Oakville ☐

Please bring your health card and this requisition form with you to your appointment.