Brockville General Hospital

GENERAL RADIOLOGY REQUISITION

- PLEASE FAX COMPLETED **GENERAL RADIOLOGY** REQUISITION TO **(855) 564-1859**

As of October 2025

PATIENT INFORMATION

Last Name	First Name	Date of Birth	YYYY	MM	DD

Address	City	Postal Code

Phone	E-mail Address	Health Card Number	Ver Code

If WSIB – Claim # ____________________________ **Date of Injury** (YYYY/MM/DD):______/____/____

CLINICAL INFORMATION

☐ **Emergent** ☐ **Next Day** ☐ **Within 10 Days** ☐ **Elective**

GENERAL RADIOLOGY

Chest
- ☐ Chest PA & LAT
- ☐ Chest PA
- ☐ Sternum
- ☐ Right Ribs/Chest PA
- ☐ Left Ribs/Chest PA
- ☐ S.C. Joints

Abdomen
- ☐ KUB
- ☐ Two Views (Upright + Supine)
- ☐ Acute Series
- ☐ Abdomen Supine (1 View)

Head & Neck
- ☐ Skull
- ☐ Facial Bones
- ☐ Nose
- ☐ Mandible
- ☐ T.M. Joints
- ☐ Neck for Soft issue
- ☐ Pre MRI Orbits

Spine
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Sacral Spine
- ☐ Scoliosis
- ☐ Sacrum
- ☐ S-I Joints
- ☐ Coccyx

Skeletal Survey
- ☐ Metastatic
- ☐ Bone Age

Upper Extremities
- ☐ L ☐ R Shoulder
- ☐ L ☐ R Clavicle
- ☐ L ☐ R AC Joints
- ☐ L ☐ R Scapula
- ☐ L ☐ R Humerus
- ☐ L ☐ R Elbow
- ☐ L ☐ R Forearm
- ☐ L ☐ R Wrist
- ☐ L ☐ R Scaphoid
- ☐ L ☐ R Hand
- ☐ L ☐ R Fingers 1 2 3 4 5

Lower Extremities
- ☐ Pelvis
- ☐ L ☐ R Hip
- ☐ L ☐ R Femur
- ☐ L ☐ R Knee
- ☐ L ☐ R Tibia & Fibula
- ☐ L ☐ R Ankle
- ☐ L ☐ R Foot
- ☐ L ☐ R Calcaneous
- ☐ L ☐ R Toes 1 2 3 4 5

OTHER:

CLINICIAN INFORMATION

Date of the Request (YYYY/MM/DD): ______/____/____

Requesting Clinician Name (PRINT First and Last Name)	Clinician Fax Number
Clinician Signature	Clinician Phone Number

REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE

Copy Report to (PRINT First and Last Name)	Copy to Fax Number

DEPARTMENT USE ONLY

Appointment Date (YYYY/MM/DD): ______/____/____ Time (hours): _________