ST. JOSEPH'S
UNITY HEALTH TORONTO

GENERAL X-RAY, ULTRASOUND,
NUCLEAR MEDICINE, FLUOROSCOPY

S0974

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

Name: _____
Male ☐ Female ☐
MRN : _____
DOB: _____
Address: _____

Telephone: _____
OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

EXAMINATION(S) REQUESTED ☐ **STAT** ☐ **URGENT** ☐ **ROUTINE** ☐ **PORTABLE**

General X-ray: _____ Ultrasound: _____

Nuclear Medicine: _____ GI/GU/Fluoroscopy: _____

Current Patient Location: ☐ Outpatient ☐ Clinic/ACC ☐ Emergency ☐ Inpatient

Study to be done as: ☐ Outpatient ☐ Inpatient

WSIB/Third Party Claim Number: _____ Preferred Days/Time (not guaranteed): _____

CLINICAL HISTORY **Isolation Precautions:** ☐ **N/A** ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Reverse**

(For Emergency Ultrasound Patients: Specify Date of Follow-up)

ADDITIONAL INFORMATION

EDC or date of Last Menstrual Period: _____ ☐ (Required for Obstetrical patients)

☐ Falls Risk ☐ Lifting Device Required ☐ Patient with Restraints (must be accompanied)

Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No

Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No

Contact Telephone Number (if different from above): _____

REQUESTING PHYSICIAN

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ Fax: _____

Copy to: _____ MD (Physician's Printed Name)

DATE/TIME	**SIGNATURE**	**PRINT NAME**
DD / Month / YYYY : h		

Reset Form

(archive: 07/2007; 02/2012; 12/2016; 06/2018; 02/2020)