Brockville General Hospital

GENERAL RADIOLOGY–FLUORO REQUISITION

- PLEASE FAX COMPLETED **GENERAL RADIOLOGY** REQUISITION TO **(855) 564-1859**
- PLEASE FAX COMPLETED **FLUOROSCOPY** REQUISITION TO **(855) 597-8505**

As of August 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 day** ☐ **Elective**

GENERAL RADIOLOGY & FLUOROSCOPY

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 Tissue
- ☐ Pre MRI Orbits

FLUOROSCOPY
- ☐ Upper GI Series/Barium Swallow
- ☐ Cystogram
- ☐ Hysterosalpingo-gram (BGH Physicians ONLY)
- ☐ Drain/Tube Check

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

☐ R ☐ L 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

☐ R ☐ L Toes
1 2 3 4 5

OTHER: Specify in clinical information section

☐ Palatopharyngeal Analysis/ Videofluoroscopic Swallow Study (VFSS): **NOT TO BE ORDERED FOR ASSESSING ESOPHAGEAL OR GASTRIC DYSFUNCTION**

Reason for Referral:

☐ Suspected/Confirmed Aspiration and/or aspiration pneumonia ☐ Previous dysphagia assessment/treatment
☐ Reduced Nutrition, hydration and/or weight loss ☐ Other (Please Specify in Clinical Information)

Severity of Dysphagia: ☐ Mild ☐ Moderate ☐ Severe ☐ Onset of Symptoms_____

Current Nutrition: ☐ NPO with G-Tube ☐ Regular Diet Texture ☐ Modified Diet Texture
☐ Other - Please Specify: _____

Recent Consultation/Investigation

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