

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

Last Name First Name Date of light Postal Code	PATIENT INFORMAT	TON										
Address City Postal Code	Last Name First I		First Nam	ame				YYY	Y	MM	DD	
Phone E-mail Address Date of Injury (YYYY/MM/DD):	A 1.1				0::		of Birth	D (
Manual M	Address				City			Posta	ii Code			
Manual M	Phone F-mail Ad			ldress	dress Health			Card Number Ver Code				
Emergent	Thome E main / d			1100			Troum Co	Toda Hambol			0. 0000	
CENERAL RADIOLOGY & FLUOROSCOPY	If WSIB – Claim # Date of Injury (YYYY/MM/D									/_		
Chest	Clinical information			☐ Emergent ☐ Next Da			lext Day	□ Within 10 day □ Elective			Elective	
Chest	, , , , , , , , , , , , , , , , , , , ,											
Chest												
Chest	GENERAL RADIOLOGY & FLUOROSCOPY											
Chest PA & LAT					<u>)</u>	Upr	oer Extrer	nities	Lower	Extre	emities	
Sternum		,										
Right Ribs/Chest PA	☐ Chest PA			☐Tho	racic Spine	ΠL	☐ R Clavi	cle		R Hip)	
Left Ribs/Chest PA	☐ Sternum			☐ Lum	bar Sacral			oints		R Fer	nur	
Sc. Joints	☐ Right Ribs/Chest PA	☐ Mandible		Spine		ΠL	☐ R Scap	ula	□L□R Knee		ee	
Abdomen NUB	☐ Left Ribs/Chest PA	☐ T.M. Joints			☐ Scoliosis		☐ R Hum	erus	□L□R Tibia&		ia &	
Abdomen KUB	☐ S.C. Joints	☐ Neck for S	oft Tissue	☐ Sacrum		□∟	□L□R Elbov		Fibula			
KUB		☐ Pre MRI O	rbits	☐ S-I J	oints		☐ R Fore	arm		R An	kle	
Two Views (Upright + Supine)	<u>Abdomen</u>			☐ Coccyx			☐ R Wris	t		R Foo	ot	
+ Supine) Series/Barium Swallow Metastatic Bone Age R L Fingers 1 2 3 4 5	☐ KUB	FLUOROSC	<u>OPY</u>				☐ R Scap	hoid		R Cal	caneous	
Acute Series	☐ Two Views (Upright						☐ R Hand	ł				
□ Abdomen Supine (1 View) □ Hysterosalpingo-gram (BGH Physicians ONLY) □ Drain/Tube Check □ Palatopharyngeal Analysis/ Videofluoroscopic Swallow Study (VFSS): NOT TO BE ORDERED FOR ASSESSING ESOPHAGEAL OR GASTRIC DYSFUNCTION ■ Previous dysphagia assessment/treatment □ 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 □ Other (Please Specify: □ Regular Diet Texture □ Modified Diet Texture □ Other - Please Specify: □ Recent Consultation/Investigation CLINICIAN INFORMATION Date of the Request (YYYY/MM/DD): □ / _ / _	• •	Series/Barium Swallow										
gram (BGH Physicians ONLY) Drain/Tube Check				☐ Bone Age					1 2 3	3 4	5	
Palatopharyngeal Analysis/ Videofluoroscopic Swallow Study (VFSS): NOT TO BE ORDERED FOR ASSESSING ESOPHAGEAL OR GASTRIC DYSFUNCTION	•					1 2 3 4 5						
Palatopharyngeal Analysis/ Videofluoroscopic Swallow Study (VFSS): 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	(1 View)											
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Reason for Referral: Suspected/Confirmed Aspiration and/or aspiration pneumonia 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 Signature Clinician Phone Number	Section											
Suspected/Confirmed Aspiration and/or aspiration pneumonia	OR GASTRIC DYSFUNCTION											
Reduced Nutrition, hydration and/or weight loss												
Severity of Dysphagia:												
CLINICIAN INFORMATION Date of the Request (YYYY/MM/DD):/ Requesting Clinician Name (PRINT First and Last Name) Clinician Signature Clinician Phone Number REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE												
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Clinician Signature Clinician Phone Number REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE	Date of the Request (YY	YY/MM/DD): _	/	_/								
REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE	Requesting Clinician Nat	me (PRINT Fire	st and Last	Name)			С	inician F	ax Numb	oer		
	Clinician Signature						С	Clinician Phone Number				
	REQUISITIONS WITHOUT	A LEGIBLE NAME.	SIGNATURE A	ND FAX NU	JMBER WILL BE	RETURI	NED, WHICH M	AY CAUSE	DELAYS IN	I PATIEI	NT CARE	
		Copy Report to (PRINT First and Last Name)										