North Bay Regional Health Centre

Diagnostic Imaging
Out-Patient Requisition

X-Ray / Ultrasound / Diagnostic Mammography
(705) 474-8600 ext. 2820 Fax: (705) 495-7984

OBSP – Breast Screening Mammogram
(705) 495-7930 Fax: (705) 495-2787

X-Ray Exams: No appointment required
Hours: Mon - Fri 8:00 a.m. – 4:00 p.m.

Patient Name:_____

Health Card #:_____

PHONE #: _____

D.O.B: _____ ❑ Male ❑ Female

Appointment Booked:_____

Please arrive 15 minutes early for all appointments and bring your health card as well as this form. Failure to do so may result in appointment rebooking.
Présentez-vous 15 minutes avant l'heure de votre rendez-vous et apportez votre carte Santé ainsi que le présent formulaire. Sinon, votre rendez-vous pourrait être remis à une autre date.

FAILURE TO COMPLETE THIS REQUISITION IN FULL WILL RESULT IN A DELAY OF BOOKING THE EXAM

Please check ☐ Yes if this patient is currently taking any cytotoxic medication

CLINICAL INFORMATION

ULTRASOUND (Appointment required)

Examination of:

Obstetrical LNMP: dd / mm / yy EDD: dd / mm / yy

☐ 1st Trimester ☐ IPS/NT (12 Weeks) ☐ Multiple Marker Screening Req.

☐ 2nd/3rd Trimester/High Risk ☐ Anatomy Scan (18-20 Weeks) ☐ BPP

Interventional ☐ Thoracentesis ☐ Paracentesis

☐ Therapeutic ☐ Diagnostic - *list all samples required:* _____

MAMMOGRAPHY (Appointment required)

☐ **OBSP – Breast Screening Mammogram**
(Call 705-495-7930 or Fax: 705-495-2787 for appt.)
People ages 40 to 74 are eligible for screening through the OBSP if they:

- Have no new breast cancer symptoms
- Have no personal history of breast cancer
- Have not had a mastectomy
- Have not had a screening mammography Within last 11 months
- If transfeminine, have used feminizing hormones for at least 5 years in a row

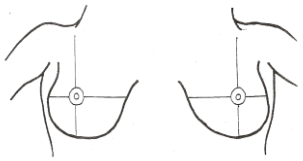
***Over age 75, requisition required for each mammo thereafter**

☐ **Stereotactic Breast Biopsy**

☐ **Non-Screening Mammogram**
Breast Implants ☐ No ☐ Yes

☐ **Breast Ultrasound**
(Call 705- 474-8600 ext 2820 or Fax: 705-495-7984 for apt)

Region of interest (for Diagnostic and U/S only)



Rt Lt

X-RAY (**No** appointment required 8-4 Mon-Fri)

Specific Area to be Examined:

May Dressings or Splints be removed: ☐ Yes ☐ No

FLUOROSCOPY (Appointment required, may include some preparation)

Example: Upper GI, SBFT, Barium Enema

Signature of Ordering Physician: _____ Print Name of Ordering Physician:_____

☐ Physician ☐ Resident ☐ Nurse Practitioner

For non NBRHC physicians: Please include Ordering Physician # for billing purposes to avoid any delays in care #_____

Address:_____

Office use only:

Patient Contact: 1. Date: _____ 2. Date: _____ 3. Date: _____

Patient Notified: Date: _____ Clerk Initial: _____ Pt Instructions:_____