ST. MICHAEL'S
UNITY HEALTH TORONTO

# X-Ray Requisition

**St Michael's Hospital Medical Imaging**
30 Bond Street, Toronto, ON, M5B 1W8
3rd Floor, Cardinal Carter wing
Fax 416-864-3051 Phone 416-864-5656
**8 a.m. to 4:30 p.m. Monday to Friday**

**GENERAL X-RAY: No prep required / No appointments necessary**

**Website: http://bit.ly/2ucQCPA**

**Sumac Creek Health Centre**
73 Regent Park Boulevard Toronto, ON
M5A 2B7 3rd Floor
Fax 416-864-6052 Phone 416-864-3022
**8:45 am to 4 pm Monday to Friday**

## A. PATIENT INFORMATION

| | |
|---|---|
| **MRN** **DOB** *YYYY/MM/DD* | **Health Card #:** **VC:** |
| **Last Name** | ☐ **Self Pay** ☐ **IFH** ☐ **WSIB Claim #**: ________________ |
| **First Name** | ☐ **Female** |
| **Street Address** | ☐ **Male** |
| **City** **Postal Code** | ☐ **Transgender - Female to Male** |
| **Province** **Country** | ☐ **Transgender - Male to Female** |
| ☐ **Interpreter: Language** ________________________________ | ☐ **Intersex** |
| ☐ **Restricted Mobility, please describe needs** ________________________________ | ☐ **Please Specify** ________________________ |
| ☐ **Isolation** ________________________________ | **Patient Consents to leave message** ☐ **Y** ☐ **N** |
| | **MOBILE:** ________________________________ |
| | **HOME:** ________________________________ |
| | **WORK:** ________________________________ |

## REQUI RED PATIENT INFORMATION

Pregnancy ☐ Y ☐ N Weight: ____________kg Height:____________

## B. EXAM INFORMATION

**Date of request:** *YYYY/MM/DD*

**Exam requested:**

**When indicated please use check box to specify side:**
☐ **R ( Right )**
☐ **L ( Left )**
☐ **B ( Bilateral )**

**Clinical information:** (be specific)

For special procedures ( joint injections/arthrograms ) appointments are required please fax request to St Michaels main site.

## C. ORDERING PHYSICIAN INFORMATION & SIGNATURE

| | | |
|---|---|---|
| **Ordering Physician Name (please print):** *Required* | | Copy to (please print): |
| **Signature:** *Required* | Date: | |
| CPSO # : | Billing # | |
| Fax # : | Phone # | |

*Form No. 73993 Dev. Apr15_2019*

**MEDICAL IMAGING X-RAY REQUISITION**