



Wentworth-Halton X-Ray and Ultrasound Inc.

Owned and Operated by The Radiologists at Hamilton Health Sciences (Hamilton General Site)

Digital Fax: 905-592-4799 | req@whxray.com | www.whxray.com |

Preferred Location: * Medical Arts -1 Young Street, Hamilton

PATIENT INFORMATION

Name: Derrick Ling

Date of Birth: 30/05/1978

Preferred Name: _____

Health Card Number: ON 8942 598 775 AN

Phone #: 647-495-0955 (H)

Sex (as per OHIP): ☐ Female ☒ Male Identifies As: _____

Appt. Date: _____ Time: _____

X-RAY (No Appointment Required)

ABDOMEN

- ☐ Flat Plate / K.U.B.
☐ Acute Series (3 views)

HEAD & NECK

- ☐ Skull
☒ Sinuses
☒ Facial Bones
☐ Nasal Bones
☐ Soft Tissue Neck / Adenoids
☐ Mandible
☐ T.M. Joints
☐ Orbits (pre-MRI)

CHEST

- ☐ Chest
☒ ☐ Ribs
☐ Sternum

SPINE & PELVIS

- ☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Sacrum / Coccyx
☐ Scoliosis
☐ S.I. Joints
☐ Pelvis

LOWER EXTREMITIES

- ☒ ☐ R Hip
☒ ☐ R Femur
☒ ☐ R Knee
☒ ☐ R Tibia & Fibula
☒ ☐ R Ankle
☒ ☐ R Os Calcis
☒ ☐ R Foot
☒ ☐ R Toe No. _____

UPPER EXTREMITIES

- ☒ ☐ R A.C. Joints
☒ ☐ R S.C. Joints
☒ ☐ R Shoulder
☒ ☐ R Scapula
☒ ☐ R Clavicle
☒ ☐ R Humerus
☒ ☐ R Elbow
☒ ☐ R Forearm
☒ ☐ R Wrist
☒ ☐ R Scaphoid
☒ ☐ R Hand
☒ ☐ R Finger No. _____

OTHER

- ☐ Specify: _____

BREAST IMAGING

(By Appointment)

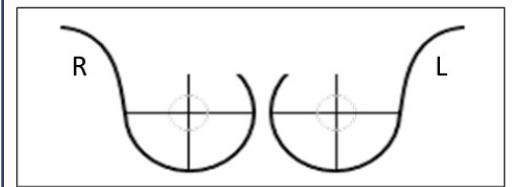
- ☐ OBSP (Ontario Breast Screening Program)
☐ Screening Mammogram
☐ Diagnostic Mammogram (use diagram below)
Indication: _____

- ☒ ☐ R Breast Ultrasound (use diagram below)

Previous? Location: _____

☒ ☐ N Date: _____

☐ Surgery: _____



ontario breast
screening program
a cancer care ontario program



Canadian Association of Radiologists
L'Association canadienne des radiologistes

ULTRASOUND (By Appointment)

ABDOMEN for Internal Organs (Requires Fasting)

- ☐ Pancreas
☐ Gallbladder / Bile Ducts
☐ Liver
☐ Aorta
☐ Kidneys
☐ Spleen
☐ Kidneys & Bladder (K.U.B. Requires Full Bladder)

ABDOMEN Other

- ☐ Appendix
☐ Hernia
Specify: _____
☐ Abdominal Wall Mass or Other
Specify: _____

VASCULAR

Arterial Studies:

- ☐ Carotid
☐ Ankle Brachial Indices (A.B.I.)
☐ Femoral Study (includes
A.B.I., Aorta, Iliacs & Femoral Arteries)

Venous Studies (D.V.T.):

- ☒ ☐ R Leg Deep Vein Thrombosis
☒ ☐ R Arm Deep Vein Thrombosis

PELVIC (Requires Full Bladder)

- ☐ Bladder
☐ Prostate
☐ Uterus / Ovaries
☐ Transvaginal (if required)

SMALL PARTS

- ☐ Scrotum
☐ Thyroid
☒ ☐ R Axilla
☐ Other: _____

MUSCULOSKELETAL (MSK)

- ☒ ☐ R Shoulder
☒ ☐ R Knee
☒ ☐ R Targeted MSK

Specify: _____

OBSTETRICAL (Requires Full Bladder)

- ☐ Dating (less than 16 weeks)
☐ IPS/eTFS (11-14 weeks)
☐ Anatomy (greater than 16 weeks)
☐ Twins or Multiple Gestation
☐ Biophysical Profile (BPP)
☐ Other: _____

BONE MINERAL DENSITOMETRY

(B.M.D.) (By Appointment)

- ☐ Baseline
☐ Low Risk Follow-Up
☐ High Risk Follow-Up

Previous? Location: _____

☒ ☐ N Date: _____

BARIUM STUDIES (GASTRICS)

(By Appointment)

- ☐ Upper G.I. Series (Double Contrast)
☐ Barium Swallow (*Digital Fluoro)
☐ Small Bowel Follow Through
☐ Surgery: _____

PRIORITY REPORT

- ☐ Request for Stat Case

Phone: _____

Fax: _____

Referring Physician Signature: X *D. Wallik* 280479

Copies To: _____

Clinical Indication, History (reason for exam):

right periorbital pain for numerous years

Date Ordered: 04/08/2021

Submit Images and Report to:

Healthcare Provider ☐

HNHB MSK-CAIC for Burlington, ☐

Hamilton, Stoney Creek & Waterdown ☐

Mississauga Halton Central Intake ☐

Program for Oakville ☐

Please bring your health card and this requisition form with you to your appointment.

This requisition form can be taken to any licensed facility providing health care services including hospitals and IHFs, such as those listed on the IHF Program website.

PATIENT INFORMATION

Please bring your health card and this requisition form with you to your appointment.

Please arrive 10 minutes earlier to register.

Please advise us of any limitations of mobility prior to your exam.

Please call and reschedule if you cannot keep your appointment. If late, you may have to rebook.

Please note that our facilities are latex-free. Persons entering our facilities are encouraged to use scent-free products.

Please refer to the exam preparations below.

PREPARATION AND INSTRUCTIONS**ULTRASOUND**

(Please advise staff if you are diabetic when making your appointment)

1. FASTING (ABDOMEN):

Nothing to eat or drink after midnight.

2. FULL BLADDER (K.U.B., PELVIC, OBSTETRICAL):

Drink one (1) litre of water, to be finished one (1) hour before your exam.

DO NOT EMPTY YOUR BLADDER.

3. FASTING AND FULL BLADDER COMBINED (ABDOMEN & PELVIC):

Nothing to eat after midnight.

Drink one (1) litre of water, to be finished one (1) hour before your exam.

DO NOT EMPTY YOUR BLADDER.

NOTES:

Appendix: For preparation instructions, please inquire at time of booking.

Hernia, Abdominal Wall Mass, Vascular, Small Parts & Musculoskeletal: No preparation required.

Pelvic: Uterus and Ovaries may require a Transvaginal exam for optimal imaging.

MAMMOGRAPHY

(Please advise staff if you have had any breast augmentation/surgery when making appointment)

Please do not use any deodorant, powder or cream on the chest/breasts/armpit area on the day of your exam

For your comfort, limit caffeine consumption two (2) days prior to your exam.

BONE MINERAL DENSITOMETRY (B.M.D.)

Please do not take any calcium supplements within twenty-four (24) hours of your exam.

If you have had another diagnostic test with dye performed within two (2) weeks of your scheduled exam, please rebook your appointment.

Bring a list of any vitamins and/or medications you are taking with you to the appointment.

If applicable, please remove your navel piercing if possible prior to your exam.

BARIUM STUDIES (GASTRICS)

(Please advise staff if you are diabetic when making appointment)

4. UPPER G.I. SERIES (Barium Meal) or BARIUM SWALLOW (Oesophagus):

Nothing to eat or drink after 10pm. Do not chew gum, eat candy or lozenge, or smoke the morning of your exam.

5. SMALL BOWEL FOLLOW THROUGH:

Purchase 1 box of PICO-SALAX at a pharmacy. Read all instructions.

Before breakfast: mix 1 sachet with 5 oz. of water, stir for 2-3 minutes (make sure it is cool before drinking) and drink contents.

Mid afternoon: prepare 2nd sachet (same mixing directions) and drink contents.

Follow meal instructions that are inside the box for breakfast, lunch and liquid supper.

No further food is allowed after supper.

Drink plenty of clear fluids, preferably water, until bowel movements have ceased.

No food allowed the morning of your exam. You may drink water to satisfy thirst.

X-RAY

(No preparation required)

Wearing light clothing without any metal, plastic, clips, snaps or beading MAY prevent having to change into a gown for the exam.

LOCATIONS**Telus PSS Users:**

Fax completed requisition to: 905-592-4799

Medical Arts X U G

1 Young Street
Hamilton, ON L8N 1T8
P: 905-522-2344 F: 905-522-5278

North Hamilton X U M

414 Victoria Avenue North
Hamilton, ON L8L 5G8
P: 905-546-5644 F: 905-546-5645

Westmount X U

723 Rymal Road West
Hamilton, ON L9B 2W2
P: 905-388-0106 F: 905-388-0313

Heritage Green X U M B

325 Winterberry Drive
Hamilton, ON L8J 0B6
P: 905-549-0433 F: 905-549-5676

Parkdale X U

132 Parkdale Avenue South
Hamilton, ON L8K 3P3
P: 905-547-3511 F: 905-547-3527

Stoney Creek X U M B

15 Mountain Avenue South
Stoney Creek, ON L8G 2V6
P: 905-662-4953 F: 905-662-1774

Waterdown X U M

245 Dundas Street East
Waterdown, ON L8B 0E9
P: 905-689-0877 F: 905-689-9918

Brant Street X U M B

760 Brant Street
Burlington, ON L7R 4B8
P: 905-637-7606 F: 905-637-2139

Fairview X U

2200 Fairview Street
Burlington, ON L7R 4H9
P: 905-333-6700 F: 905-333-2670

Walkers Line X U M B G

2951 Walkers Line
Burlington, ON L7M 4Y1
P: 905-336-2202 F: 905-336-9596

Appleby Line X U

1960 Appleby Line
Burlington, ON L7L 0B7
P: 905-331-5438 F: 905-331-2169

Speers X U M B

1060 Speers Road
Oakville, ON L6L 2X4
P: 905-844-0181 F: 905-844-0182

Palermo X U

2525 Old Bronte Road
Oakville, ON L6M 4J2
P: 905-469-2524 F: 905-469-3555

Argus X U

581 Argus Road
Oakville, ON L6J 3J4
P: 905-338-6644 F: 905-338-6656



X-RAY = X
ULTRASOUND = U
MAMMOGRAPHY = M
BONE MINERAL DENSITOMETRY = B
BARIUM STUDIES (GASTRICS) = G

Ontario Ministry of Health and Long-Term Care Laboratory Requisition Requisitioning Clinician / Practitioner		Laboratory Use Only					
Name David W. Wallik							
Address 3305 Harvester Road, Units 15-20 Burlington, ON L7N 3N2		Clinician/Practitioner's Contact Number for Urgent Results (905) 632-8007 Ext.				Service Date yyyy mm dd	
Clinician/Practitioner Number 280479	CPSO / Registration No. 53982	Health Number ON 8942 598 775	Version AN	Sex ☒ M ☐ F	Date of Birth yyyy mm dd 1978 05 30		
Check (✓) one: ☒ OHIP/Insured ☐ Third Party / Uninsured ☐ WSIB		Province		Other Provincial Registration Number		Patient's Telephone Contact Number (647) 495-0955	
Additional Clinical Information (e.g. diagnosis)		Patient's Last Name (as per OHIP Card) Ling					
		Patient's First & Middle Names (as per OHIP Card) Derrick					
☐ Copy to: Clinician/Practitioner Last Name: First Name		Patient's Address (including Postal Code) 963 King Road Unit 20 Burlington, ON L7T 3L2					
Address							
Note: Separate requisitions are required for cytology, histology / pathology, ColonCancerCheck FIT test, and tests performed by Public Health Laboratory							
x	Biochemistry	x	Hematology		x	Viral Hepatitis (check one only)	
	Glucose ☐ Random ☐ Fasting		CBC			Acute Hepatitis	
	HbA1C		Prothrombin Time (INR)			Chronic Hepatitis	
	Creatinine (eGFR)		Immunology			Immune Status / Previous Exposure	
	Uric Acid		Pregnancy Test (Urine)			Specify: ☐ Hepatitis A	
	Sodium		Mononucleosis Screen			☐ Hepatitis B	
	Potassium		Rubella			☐ Hepatitis C	
	ALT		Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)			or order individual hepatitis tests in the "Other Tests" section below	
	Alk. Phosphatase		Repeat Prenatal Antibodies			Prostate Specific Antigen (PSA)	
	Bilirubin					☐ Total PSA ☐ Free PSA	
	Albumin		Microbiology ID & Sensitivities (if warranted)			Specify one below:	
	Lipid Assessment (includes Cholesterol, HDL-C, Triglycerides, calculated LDL-C & Chol/HDL-C ratio; individual lipid tests may be ordered in the "Other Tests" section of this form)		Cervical			☐ Insured – Meets OHIP eligibility criteria	
			Vaginal			☐ Uninsured – Screening: Patient responsible for payment	
	Albumin / Creatinine Ratio, Urine		Vaginal / Rectal – Group B Strep			Vitamin D (25-Hydroxy)	
	Urinalysis (Chemical)		Chlamydia (specify source):			☐ Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism	
	Neonatal Bilirubin:		GC (specify source):			☐ Uninsured - Patient responsible for payment	
	Child's Age: days hours		Sputum			Other Tests - one test per line	
	Clinician/Practitioner's tel. no.		Throat			ABO/Rh	
	Patient's 24 hr telephone no. (		Wound (specify source):				
	Therapeutic Drug Monitoring:		Urine				
	Name of Drug #1		Stool Culture				
	Name of Drug #2		Stool Ova & Parasites				
	Time Collected #1 hr. #2 hr.		Other Swabs / Pus (specify source):				
	Time of Last Dose #1 hr. #2 hr.						
	Time of Next Dose #1 hr. #2 hr.						
I hereby certify the tests ordered are not for registered in or out patients of a hospital.		Specimen Collection					
		Time 24 hour clock		Date yyyy/mm/dd			
		Laboratory Use Only					
X Signature		04/08/2021 Date					