St. Michael's
Inspired Care. Inspiring Science.

X-Ray Requisition

St Michael's Hospital Medical Imaging
30 Bond Street, Toronto, ON, M5B 1W8
3rd Floor, Cardinal Carter wing
Fax 416-864-3019 Phone 416-864-5656

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

A. PATIENT INFORMATION

MRN **DOB** *YYYY/MM/DD*

Last Name

First Name

Street Address

City **Postal Code**

Province **Country**

☐ **Interpreter: Language** _____

_____

☐ **Restricted Mobility, please describe needs**

_____

☐ **Isolation** _____

Health Card #: **VC:**

☐ **Self Pay** ☐ **IFH** ☐ **WSIB Claim #:** _____

☐ **Female**
☐ **Male**
☐ **Transgender - Female to Male**
☐ **Transgender - Male to Female**
☐ **Intersex**
☐ **Please Specify** _____

Patient Consents to leave message ☐ **Y** ☐ **N**

MOBILE: _____

HOME: _____

WORK: _____

REQUIRED 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. 08/2018

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