

BAYVIEW DIAGNOSTIC CENTRE

B01-9160 BAYVIEW AVE, RICHMOND HILL, L4B 0E6

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NAME: _____ D.O.B. _____ TEL: _____ DATE: _____

STAT

REQUEST FOR ASSESSMENT

VERBAL

<p style="text-align: center; background-color: #f2f2f2; margin: 0;">PERIPHERAL ARTERIAL</p> <p><input type="checkbox"/> Lower Extremity (incl. Aorta, ABI, TBI)</p> <p><input type="checkbox"/> Carotids</p> <p><input type="checkbox"/> Upper Extremity (incl. DBI)</p> <p><input type="checkbox"/> Renal Arteries Stenosis (incl. ABI, TBI)</p> <p><input type="checkbox"/> Diabetic Foot</p> <p><input type="checkbox"/> Leg Ulcers <input type="checkbox"/> WOUND CARE</p> <hr/> <p style="text-align: center; background-color: #f2f2f2; margin: 0;">PERIPHERAL VENOUS</p> <p><input type="checkbox"/> Lower Extremity (incl. Ivc)</p> <p><input type="checkbox"/> Upper Extremity</p> <p><input type="checkbox"/> Venous mapping</p> <p><input type="checkbox"/> Leg Ulcers <input type="checkbox"/> WOUND CARE</p> <hr/> <p style="text-align: center; background-color: #f2f2f2; margin: 0;">CARDIO</p> <p><input type="checkbox"/> Echocardiogram</p> <p><input type="checkbox"/> Digital Holter Monitoring</p> <p><input type="checkbox"/> 24Hrs <input type="checkbox"/> 48Hrs</p> <p><input type="checkbox"/> 72Hrs <input type="checkbox"/> 2 weeks</p> <hr/> <p style="text-align: center; background-color: #f2f2f2; margin: 0;"><input type="checkbox"/> CONSULTING SPECIALIST VASCULAR/CARDIO IF ABNORMAL</p>	<p style="text-align: center; background-color: #f2f2f2; margin: 0;">X-RAY</p> <div style="display: flex;"> <div style="flex: 1; border-right: 1px solid black; padding-right: 5px;"> <p>HEAD & NECK</p> <p><input type="checkbox"/> Skull</p> <p><input type="checkbox"/> Sinuses</p> <p><input type="checkbox"/> Mastoids</p> <p><input type="checkbox"/> Adenoids</p> <p><input type="checkbox"/> Pit. Fossa</p> <p><input type="checkbox"/> Facial Bones</p> <p><input type="checkbox"/> Nasal Bones</p> <p><input type="checkbox"/> Mandible</p> <p><input type="checkbox"/> T.M. Joints</p> <p><input type="checkbox"/> I.A. Meati</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Orbits</p> <p>SKELETAL SURVEY</p> <p><input type="checkbox"/> Metastatic Series</p> <p><input type="checkbox"/> Arthritic Series</p> <p>ABDOMEN</p> <p><input type="checkbox"/> Single view (KUB)</p> <p><input type="checkbox"/> Acute (3 views)</p> <p>SPINE & PELVIS</p> <p><input type="checkbox"/> Cervical Spine</p> <p><input type="checkbox"/> Dorsal Spine</p> <p><input type="checkbox"/> Scoliosis Series</p> <p><input type="checkbox"/> Lumbar Spine (3 views)</p> <p><input type="checkbox"/> Lumbar Spine (5 views) (with obliques)</p> <p><input type="checkbox"/> Thoracic Spine</p> <p><input type="checkbox"/> L/S Spine, Pelvis & S.I. Joints</p> <p><input type="checkbox"/> Sacrum & Coccyx</p> <p><input type="checkbox"/> S.I. Joints</p> <p><input type="checkbox"/> Pelvis & Hip</p> </div> <div style="flex: 1; padding-left: 5px;"> <p>CHEST</p> <p><input type="checkbox"/> Chest (PA & LAT)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ribs & Chest PA</p> <p><input type="checkbox"/> Chest PA</p> <p><input type="checkbox"/> Sternum</p> <p><input type="checkbox"/> Stemo-Clavicular Joints</p> <p><input type="checkbox"/> Immigration (PA)</p> <p>UPPER EXTREMITIES</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Clavicle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> A.C. Joints</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Scapula</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Humerus</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbow</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Forearm</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wrist</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Scaphoid</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Digit No. 1 2 3 4 5</p> <p>LOWER EXTREMITIES</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hip</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Femur</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knee</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tib & Fib</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ankle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stress Views</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Os Calcis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Toes No. 1 2 3 4 5</p> </div> </div>						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 2px;">CLINICAL INFORMATION:</td> <td style="width: 40%; padding: 2px;">APPOINTMRNT DATE:</td> </tr> <tr> <td style="padding: 2px;">REFERRING DOCTOR:</td> <td style="padding: 2px;">APPOINTMRNT TIME:</td> </tr> <tr> <td style="padding: 2px;">BILLING#:</td> <td></td> </tr> </table>		CLINICAL INFORMATION:	APPOINTMRNT DATE:	REFERRING DOCTOR:	APPOINTMRNT TIME:	BILLING#:	
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This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website:
<http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx>