X-Ray & Ultrasound

HALIBURTON HIGHLANDS HEALTH SERVICES

Fax: 705 – 457 – 1071

Booking Line: 705 – 457 – 1392 Ext. 2381

Outpatient
Inpatient
Room: _____

DATE TO BE DONE BY/WITHIN

_____

2 Days
7 Days
10 Days

Date of Requisition: _____

Name: _____

Health Card #: _____

Birthdate: _____

Phone: _____

Ordering Physician: _____

Family Physician: _____

CC Physician: _____

WSIB ☐ No ☐ Yes

Injury Date: _____

Claim #: _____

X-RAY

Requested Examination:

Essential Clinical History:

Physician's Signature: _____ Date: _____

ULTRASOUND

Requested Examination:

Essential Clinical History:

Physician's Signature: _____ Date: _____

Appointment Date: _____ **Time:** _____ **MRN:** _____

PREP: _____