X-RAY REQUISITION

Telephone: 613-584-3333 ext. 7600 **Fax:** 613-584-3890

Isolation Required
☐ **Routine** ☐ **Contact** ☐ **Contact/Droplet** ☐ **Airborne**

Patient Information:	**Date Ordered:**	
	Outpatient	☐
	Inpatient	☐
	Room number	
	Wheelchair	☐
	Stretcher	☐
	Fall Risk	☐
Do not write in this space *For office use only*	**WSIB *only*** Employer: Address: Date of Injury: SIN:	

Examination Requested	**Reason For Exam/Relevant History**
	Authorized Signature
	Ordering Physician Printed Name

Deep River & District Hospital also accepts diagnostic imaging referrals through the Ocean eReferral Network. We encourage providers to take advantage of this secure, streamlined method for submitting referrals. Visit oceanhealthmap.ca and search "Deep River" to locate our services.