

Patient Information

Last Name _____ First Name _____

Birthdate / / / OHIP - - VC

dd mm yyyy xxx xxx xxx


Address _____

City _____ Postal Code _____

Phone () - - Sex M F

Referring Physician

Name _____

Signature 

Copy to: _____

Chiro Consult Required Y N Billing Number: _____

Clinical Information

VERBAL Contact Number: _____

STAT REPORT REQUIRED

Ultrasound

<p>Obstetrical</p> <p><input type="checkbox"/> Dual Scan Series: NT Scan (11-14 wks.); Anatomical (18-20 wks.)</p> <p><input type="checkbox"/> NT Scan (11-14 wks.)</p> <p><input type="checkbox"/> Anatomical (18-20 wks.)</p> <p><input type="checkbox"/> Obstetrical</p> <p><input type="checkbox"/> Biophysical profile</p> <p><input type="checkbox"/> Twins</p> <p><input type="checkbox"/> 3D Ultrasound</p> <p>Other (please specify) _____</p>	<p>Female Reproductive</p> <p><input type="checkbox"/> Follicular Monitoring</p> <p><input type="checkbox"/> Sonohysterography</p> <p><input type="checkbox"/> Sonohysterography with contrast (for tubal patency investigation)</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>LMP</p> <p><u> </u> / <u> </u> / <u> </u></p> <p style="text-align: center;"><small>dd mm yyyy</small></p> </div>	<p>Abdominal/Pelvic</p> <p><input type="checkbox"/> Abdominal</p> <p><input type="checkbox"/> Pelvic</p> <p><input type="checkbox"/> Transvaginal</p> <p><input type="checkbox"/> Transrectal</p> <p><input type="checkbox"/> G.U. Tract</p> <p><input type="radio"/> Kidneys</p> <p><input type="radio"/> Bladder (Prostate)</p>	<p>Small Parts</p> <p><input type="checkbox"/> Scrotal</p> <p><input type="checkbox"/> Thyroid</p> <p>R L</p> <p><input type="checkbox"/> <input type="checkbox"/> Groin Mass/ Inguinal Area</p> <p>Musculo-skeletal</p> <p>R L</p> <p><input type="checkbox"/> <input type="checkbox"/> Body Part(s) (please specify) _____</p>	<p>Vascular (Coxwell)</p> <p><input type="checkbox"/> Carotid Duplex</p> <p><input type="checkbox"/> Arterial Duplex (upper)</p> <p><input type="checkbox"/> Arterial Duplex (lower)</p> <p><input type="checkbox"/> Venous Duplex (upper)</p> <p><input type="checkbox"/> Venous Duplex (lower)</p>
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X-Ray

Please specify (right/left/bilateral & body part(s)) _____

Breast Imaging

Screening Mammogram with OBSP


Mammogram

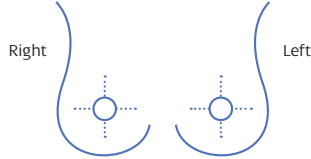
Right Left Bilat.

Ultrasound

Right Left Bilat.

IMPLANTS



Right  Left

Please indicate location and size of lesion

Bone Mineral Density

Baseline (One per lifetime)

High risk annual


Low risk (3 years after baseline, subsequent studies after 5 years)

Prior BMD Date: / /

dd mm yyyy

Risk category*: _____

*See www.health.on.gov.ca for BMD risk and MOH billing information.



Appointment Location

Central Toronto Diagnostic Imaging Malvern Ultrasound & Mammography Mississauga Diagnostic Imaging & Breast Centre

Coxwell Ultrasound Victoria Terrace X-Ray & Ultrasound (Don Mills) Insight Diagnostic Imaging

***Please ensure that required services are offered at chosen location (reverse).**

Your Appointment:

Date: / / Time: am/pm
 dd / mm / yyyy

Location (locations listed on right):

Please bring your Ontario Health Card along with this requisition to your appointment. If you are unable to keep this appointment, please give at least 24 hours notice.

Preparation and Instructions:

These instructions are IMPORTANT. Please follow them.

X-RAY (X)

If you are pregnant or think you might be, please talk to your doctor before having an x-ray. Women who think they may be pregnant should not have an x-ray during the last two weeks of their menstrual cycle.

Mammography (M)

On the day of the examination, after showering, please **do not use deodorant, anti-perspirant or talcum powder** on your chest or underarms since particles in these may show up on the mammogram.

Bone Mineral Density (B)

It is preferable to wear clothing without zippers or fasteners (e.g. jogging suit or leggings). On the day of the examination do not take calcium supplements or iron tablets until after the examination.

Ultrasound (U)

ABDOMEN: Includes studies of the GALL BLADDER, PANCREAS, SPLEEN, LIVER, KIDNEYS, and AORTA.

If your appointment is in the morning, do not eat or drink anything after midnight the night before. If your appointment is in the afternoon, for breakfast you may eat dry toast, black tea, black coffee, and juice up to 9 a.m. but have nothing to eat or drink after that. These instructions are important as we require you to have an empty stomach.

PELVIS: Includes TRANSVAGINAL (UTERUS, OVARIES, BLADDER) and PREGNANCY (OBSTETRICAL)

You must have a full bladder for this examination. Please start drinking 1 1/2 hours before your appointment and finish 45 minutes before the appointed time. You must drink 3 cups (24 oz / 750 mL) of fluid. This can include coffee, tea, juice, water etc. but not milk. **Do not go to the washroom.** We will try to examine you as soon as possible on arrival so that you won't be uncomfortable for too long. Eat the meal nearest your examination (there is no reason not to eat).

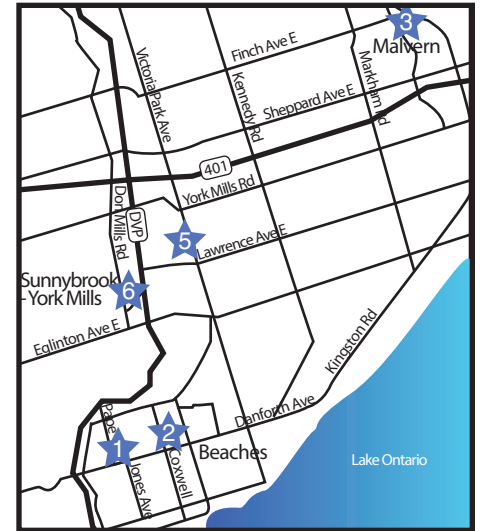
ABDOMEN and PELVIS combined examinations (ALSO G.U. TRACT)

You must have an empty stomach and full bladder. Do not eat anything within 12 hours of the examination. Finish drinking 3 cups (24 oz / 750 mL) of water (*and only water*) 45 minutes before your examination. **Do not go to the washroom.**

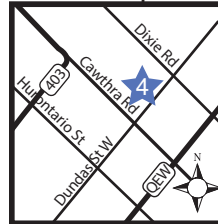
PROSTATE with TRANSRECTAL

Take a mild laxative the evening before your appointment (PROSTATE ONLY - OMIT LAXATIVE). Please start drinking 1 1/2 hours before your appointment and finish 45 minutes before the appointed time. You must drink 3 cups (24 oz / 750 mL) of water.

Toronto East



Mississauga



Radiology services offered vary by location. Please see below for our locations and the services offered.

X: X-RAY U: Ultrasound M: Mammography B: Bone Mineral Density

Location	Services Offered
<input type="checkbox"/> Central Toronto Diagnostic Imaging*^ 1 (Pape and Danforth) 658 Danforth Avenue, Main Floor, Toronto T 416-465-5735 F 416-465-1402	XUMB
<input type="checkbox"/> Coxwell Ultrasound (Coxwell and Danforth) 2 1577 Danforth Avenue, Unit 7, Toronto T 416-465-4679 F 416-465-2150	UV
<input type="checkbox"/> Malvern Ultrasound & Mammography*^ 3 1333 Neilson Road, Suite 230, Scarborough T 416-282-1147 F 416-282-2746	UM
<input type="checkbox"/> Mississauga Diagnostic Imaging and Breast Centre*^ 4 (East of Cawthra) 801 Dundas Street East, Mississauga T 905-897-9711 F 905-897-9844	XUMB Now OBSP
<input type="checkbox"/> Victoria Terrace X-Ray & Ultrasound* 5 (West side of Victoria Terrace Mall) 1448 Lawrence Avenue East, Suite 209 T 416-750-4555 F 416-750-4568	XUB
<input type="checkbox"/> (Don Mills) Insight Diagnostic Imaging 6 18 Wynford Drive, Suite 507, Toronto T 416-449-8289 F 416-449-9643	XUM Xray as of Fall, 2014

* Ontario Breast Screening Program (OBSP) Site

^ Accredited for Bone Mineral Densitometry by the Ontario Association of Radiologists

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