

Patient Information

Last Name _____ First Name _____

Birthdate / / OHIP - - Sex M F
dd mm yyyy xxx xxx VC

Address _____

City _____ Postal Code _____

Phone (day) () - (evening) () -

Referring Physician

Name _____ Phone () -

Address _____

Verbal Fax () - Copy to: _____

Signature _____

Chiropractic Referral: _____ Consult Required? Y N

Billing Number _____

Ultrasound

<input type="checkbox"/> Thyroid and Neck	Vascular (Coxwell)
<input type="checkbox"/> Scrotal	<input type="checkbox"/> Carotid Duplex
<input type="checkbox"/> G.U. Tract <input type="radio"/> Kidneys <input type="radio"/> Bladder (Prostate)	<input type="checkbox"/> Arterial Duplex <input type="radio"/> (upper) <input type="radio"/> (lower)
<input type="checkbox"/> Transrectal / Prostate <input type="radio"/> Include Kidneys & Bladder	<input type="checkbox"/> Venous Duplex <input type="radio"/> (upper) <input type="radio"/> (lower)
<input type="checkbox"/> Follicular Monitoring	<input type="checkbox"/> Vascular Screening (Carotid, Aorta, Legs)
Obstetrics Gynecology	<input type="checkbox"/> Venous Insufficiency
<input type="checkbox"/> Female Pelvic / Transvaginal <input type="radio"/> Pelvic only <input type="radio"/> T/V only	<input type="checkbox"/> Renial Arterial
<input type="checkbox"/> Dual Scan Series: NT Scan (11-14 wks.); Anatomical (18-20 wks.)	<input type="checkbox"/> Diabetic Foot Assessment
<input type="checkbox"/> NT Scan (11-14 wks.)	Musculo-skeletal
<input type="checkbox"/> Obstetrical	R L
<input type="checkbox"/> Biophysical profile	<input type="checkbox"/> Shoulder/AC Joint
<input type="checkbox"/> Twins	<input type="checkbox"/> Elbow
<input type="checkbox"/> Sonohysterography	<input type="checkbox"/> Wrist/Hand
<input type="checkbox"/> 3D Ultrasound	<input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> Fallopian Tubes	<input type="checkbox"/> Groin Mass/Inguinal Area
Abdominal/Pelvic	<input type="checkbox"/> Hip
<input type="checkbox"/> Abdominal	<input type="checkbox"/> Hamstring
<input type="checkbox"/> Male Pelvic (Pre- and Post-Void)	<input type="checkbox"/> Knee
Other (please specify) _____	<input type="checkbox"/> Calf
	<input type="checkbox"/> Ankle/Foot
	<input type="checkbox"/> Achilles Tendon
	<input type="checkbox"/> Plantar Fascia

X-Ray


Upper Extremities	Chest	Abdomen
R L	<input type="checkbox"/> Chest PA & Lat	<input type="checkbox"/> KUB
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Chest PA Ins, Exp & Lat	<input type="checkbox"/> Acute ABD
<input type="checkbox"/> Clavicle	<input type="checkbox"/> Chest PA	Head & Neck
<input type="checkbox"/> AC Joint	<input type="checkbox"/> Sternum	<input type="checkbox"/> Neck (Soft Tissue)
<input type="checkbox"/> Scapula	<input type="checkbox"/> Ribs & Chest PA	<input type="checkbox"/> Skull
<input type="checkbox"/> Humerus	<input type="radio"/> B <input type="radio"/> R <input type="radio"/> L	<input type="checkbox"/> Orbits
<input type="checkbox"/> Elbow	Spine & Pelvic	<input type="checkbox"/> Orbits for foreign body
<input type="checkbox"/> Forearm	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Facial bones
<input type="checkbox"/> Wrist	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Nasal bones
<input type="checkbox"/> Scaphoid	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Mandible
<input type="checkbox"/> Bone Age Hand & Wrist	<input type="checkbox"/> Sacrum / Coccyx	<input type="checkbox"/> Sinus
<input type="checkbox"/> Hand	<input type="checkbox"/> Sacroiliac Joints	<input type="checkbox"/> TM Joints
<input type="checkbox"/> Finger	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Adenoids
Digit: 1 2 3 4 5	<input type="checkbox"/> Skeletal Survey	
Lower Extremities	<input type="checkbox"/> Pelvis	
R L	<input type="checkbox"/> Pelvis & Hips	
<input type="checkbox"/> Hip	Other (please specify)	
<input type="checkbox"/> Femur	_____	
<input type="checkbox"/> Knee	_____	
<input type="checkbox"/> Tib / Fib	_____	
<input type="checkbox"/> Ankle	_____	
<input type="checkbox"/> Foot	_____	
<input type="checkbox"/> Toe	_____	
Digit: 1 2 3 4 5	_____	
<input type="checkbox"/> OS Calcis	_____	

Breast Imaging

Screening Mammogram with OBSP

Mammogram
 Right Left Bilat.

Ultrasound
 Right Left Bilat.



Please indicate location and size of lesion


Bone Mineral Density

Baseline (One per lifetime) Prior BMD Date: / /

High risk annual dd mm yyyy

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

Risk category*: _____

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

Clinical Information

STAT REPORT REQUIRED



Canadian Association of Radiologists

Appointment Location

- Central Toronto Diagnostic Imaging Spadina-Bloor Ultrasound 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.

Please arrive 15 minutes prior to your appointment time.

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.**

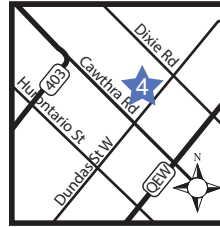
PROSTATE with TRANSRECTAL

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



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*^ (Pape and Danforth) 1 658 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"/> Spadina-Bloor Ultrasound 3 1333 Neilson Road, Suite 230, Scarborough T 416-519-9699 F 416-519-6899	U
<input type="checkbox"/> Mississauga Diagnostic Imaging and Breast Centre*^ (East of Cawthra) 4 801 Dundas Street East, Mississauga T 905-897-9711 F 905-897-9844	XUMB
<input type="checkbox"/> Victoria Terrace X-Ray & Ultrasound* (West side of Victoria Terrace Mall) 5 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	UM

* Ontario Breast Screening Program (OBSP) Site

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

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