

# DIAGNOSTIC IMAGING REQUISITION

Patient Label

Telephone: (905) 883-2004 Or (905) 832-4554 Ext. 2004 Fax: (905) 883-0772

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ HEALTH CARD NO. \_\_\_\_\_  
dd/mm/yyyy

TELEPHONE: \_\_\_\_\_ CAN WE LEAVE A VOICEMAIL?  YES  NO

ADDITIONAL REPORTS TO: \_\_\_\_\_ DATE: \_\_\_\_\_  
dd/mm/yyyy

REFERRING DOCTOR'S NAME & SIGNATURE: \_\_\_\_\_

SEE REVERSE FOR PREPARATION INFORMATION

**IMPORTANT APPOINTMENT INFORMATION:**

Patient to arrive 20 mins prior to appointment, unless otherwise indicated by the scheduler.

Patient to check in using our self-serve kiosks, located in Patient Registration Level 2, C Wing.

PERTINENT CLINICAL FINDINGS

NB - CLINICAL INFORMATION IS ESSENTIAL FOR INTERPRETATION OF THE REQUESTED STUDIES

### ULTRASOUND

<b>OBSTETRICAL</b> <input type="checkbox"/> IPS NT MEASUREMENT/ (11 - 14 WKS) <input type="checkbox"/> DETAILED OB SCAN (18-20 WKS) <input type="checkbox"/> HIGH RISK <input type="checkbox"/> R/O ECTOPIC <input type="checkbox"/> DATING OBS  <b>GENERAL</b> <input type="checkbox"/> ABDOMEN <input type="checkbox"/> RENAL <input type="checkbox"/> BLADDER / PROSTATE <input type="checkbox"/> PELVIC / TV <input type="checkbox"/> PELVIC <input type="checkbox"/> PRE / POST VOID <input type="checkbox"/> GROINS <input type="checkbox"/> THYROID <input type="checkbox"/> TESTICULAR <input type="checkbox"/> SALIVARY GLANDS <input type="checkbox"/> BREAST <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> BRAIN	<b>VASCULAR ULTRASOUND</b> <input type="checkbox"/> CAROTIDS <input type="checkbox"/> VEINS OF LEGS <input type="checkbox"/> VENOUS LEG <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> VENOUS ARM <input type="checkbox"/> Rt <input type="checkbox"/> Lt  <b>MUSCULO-SKELETAL</b> <input type="checkbox"/> SHOULDER <input type="checkbox"/> ELBOW <input type="checkbox"/> HAMSTRINGS <input type="checkbox"/> KNEE <input type="checkbox"/> FOOT <input type="checkbox"/> ACHILLES TENDON <input type="checkbox"/> ANKLES <input type="checkbox"/> HANDS <input type="checkbox"/> FINGER <input type="checkbox"/> PORTAL VEIN DOPPLER/ TIPS SHUNT DOPPLER <input type="checkbox"/> RENAL DOPPLER <input type="checkbox"/> AXILLA <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> OTHER
---	---

### NUCLEAR MEDICINE / RADIOLOGY

POSSIBILITY OF PREGNANCY AND/OR BREASTFEEDING?  YES  NO

<b>CARDIAC</b> <input type="checkbox"/> EXERCISE MYOCARDIAL PERFUSION <input type="checkbox"/> PERSANTINE MYOCARDIAL PERFUSION <input type="checkbox"/> RESTING VENTRICULAR FUNCTION (Rest MUGA) <input type="checkbox"/> THALLIUM REST/ REDISTRIBUTION (VIABILITY STUDY)  <b>NERVOUS</b> <input type="checkbox"/> BRAIN PERFUSION SPECT  <b>GASTROINTESTINAL</b> <input type="checkbox"/> LIVER / SPLEEN (SULPHUR COLLOID) <input type="checkbox"/> R.B.C. LIVER <input type="checkbox"/> HEPATOBILIARY (HIDA) <input type="checkbox"/> GASTRIC EMPTYING <input type="checkbox"/> SALIVARY	<b>SKELETAL</b> <input type="checkbox"/> BONE / WHOLE BODY <input type="checkbox"/> BONE (specify) _____  <b>ENDOCRINE</b> <input type="checkbox"/> THYROID UPTAKE & SCAN <input type="checkbox"/> PARATHYROID  <b>RESPIRATORY</b> <input type="checkbox"/> VENTILATION/PERFUSION LUNG  <b>GENITOURINARY</b> <input type="checkbox"/> RENAL FLOW & DIFFERENTIAL FUNCTIONAL (DTPA) <input type="checkbox"/> RENAL LASIX <input type="checkbox"/> RENAL CAPTOPRIL  <b>OTHER NUCLEAR MEDICINE</b> <input type="checkbox"/> GALLIUM (specify): _____ <input type="checkbox"/> SENTINEL NODE _____ <input type="checkbox"/> OTHER (Specify): _____
---	--

### ECHOCARDIOGRAPHY


COMPLETE ECHO / DOPPLER STUDY  
 OTHER \_\_\_\_\_

Please include indication \_\_\_\_\_

### BONE MINERAL DENSITY (BMD)

HIGH RISK  LOW RISK Date of last exam: \_\_\_\_\_  
dd/mm/yyyy

### MAMMOGRAPHY



RIGHT LEFT

Please indicate location and size of lesion

DIAGNOSTIC  
 OBSP ROUTINE  
 MAMMOGRAM  
 IMPLANTS  
 RIGHT  LEFT

### X-RAYS

<b>CHEST</b> <input type="checkbox"/> CHEST PA & LAT <input type="checkbox"/> CHEST PA <input type="checkbox"/> STERNUM <input type="checkbox"/> RIBS & CHEST PA <input type="checkbox"/> R <input type="checkbox"/> L  <b>ABDOMEN</b> <input type="checkbox"/> KUB <input type="checkbox"/> TWO VIEWS  OTHER _____	<b>HEAD &amp; NECK</b> <input type="checkbox"/> SINUSES <input type="checkbox"/> SKULL <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> NOSE <input type="checkbox"/> MANDIBLE <input type="checkbox"/> T.M. JOINTS <input type="checkbox"/> ADENOIDS <input type="checkbox"/> NECK FOR SOFT TISSUE	<b>SPINE</b> <input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> SCOLIOSIS <input type="checkbox"/> SACRUM & COCCYX <input type="checkbox"/> S-1 JTS  <b>SKELETAL SURVEY</b> <input type="checkbox"/> ARTHRITIC <input type="checkbox"/> METASTATIC <input type="checkbox"/> BONE AGE	<b>UPPER EXTREMITIES</b> <input type="checkbox"/> R <input type="checkbox"/> L SHOULDER <input type="checkbox"/> R <input type="checkbox"/> L CLAVICLE <input type="checkbox"/> R <input type="checkbox"/> L AC JOINTS <input type="checkbox"/> R <input type="checkbox"/> L SCAPULA <input type="checkbox"/> R <input type="checkbox"/> L HUMERUS <input type="checkbox"/> R <input type="checkbox"/> L ELBOW <input type="checkbox"/> R <input type="checkbox"/> L FOREARM <input type="checkbox"/> R <input type="checkbox"/> L WRIST <input type="checkbox"/> R <input type="checkbox"/> L SCAPHOID <input type="checkbox"/> R <input type="checkbox"/> L HAND <input type="checkbox"/> R <input type="checkbox"/> L FINGERS	<b>LOWER EXTREMITIES</b> <input type="checkbox"/> PELVIS <input type="checkbox"/> R <input type="checkbox"/> L HIP <input type="checkbox"/> R <input type="checkbox"/> L FEMUR <input type="checkbox"/> R <input type="checkbox"/> L KNEE <input type="checkbox"/> R <input type="checkbox"/> L TIBIA & FIBULA <input type="checkbox"/> R <input type="checkbox"/> L ANKLE <input type="checkbox"/> R <input type="checkbox"/> L FOOT <input type="checkbox"/> R <input type="checkbox"/> L CALCANEUS <input type="checkbox"/> R <input type="checkbox"/> L TOES
--	---	---	---	---

**PLEASE: BRING THIS PAPER TO**

**NUCLEAR MEDICINE**

Thallium Prep	- Nothing to eat or drink after midnight.	Hepatobiliary (HIDA) Prep	- Nothing to eat or drink 4 hours prior to exam.
Renal Prep	- Well hydrated; Full bladder is <u>not</u> necessary		
Gastric Emptying Prep	- Nothing to eat or drink after midnight.		

**TIME REQUIRED FOR NUCLEAR SCANS**

Bone - 4 hours	Liver & Spleen - 1 hour	RBC Liver - 2 hours	Thyroid: First Day - 10 minutes
Brain - Up to 2.5 hours	Lung - 1 hour	Renal - 1 - 2 hours	Second Day - 1 hour
BMD - 20 minutes	Myocardial Perfusion (Exercise or Persantine) 4 - 6 hours		

There are no side effects from these examinations

**ULTRASOUND PREPARATIONS**

- Obstetrical or Pelvic Ultrasound  
You need a FULL BLADDER. FINISH DRINKING 40 FLUID OUNCES OF WATER (5 - 8 OZ. GLASSES) 1 hour before your examination. DO NOT VOID.
- COMBINATION PELVIC AND ABDOMINAL ULTRASOUND  
Nothing to eat for 8 hours, but COMPLETE DRINKING 40 OUNCES OF WATER 1 HOUR BEFORE. DO NOT VOID
- ABDOMEN - GALL BLADDER - KIDNEYS  
A.M. EXAM - Nothing to eat or drink after midnight.  
P.M. EXAM - Light breakfast (no eggs or dairy products) Nothing to eat or drink after this light breakfast.

**MAMMOGRAPHY**

If you have had previous mammograms taken at another hospital or clinic, please arrange to bring them with you as they will be needed for comparison with your current X-Rays.

Please **DO NOT WEAR** any deodorant, talcum powder or perfume on the day of your examination.

# Mackenzie Richmond Hill Hospital

