

Patient Label

# DIAGNOSTIC IMAGING REQUISITION

Telephone: (905) 883-2004 Fax: 905-883-0772

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

DATE OF: \_\_\_\_\_ HEALTH CARD NO. \_\_\_\_\_

BIRTH 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 by the scheduler.

Patient to check in using our self-serve, kiosks location in Patient Registration.

PERTINENT CLINICAL FINDINGS

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

ULTRASOUND	NUCLEAR MEDICINE / RADIOLOGY
<p><b>OBSTETRICAL</b></p> <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 <p><b>GENERAL</b></p> <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 <p><b>VASCULAR ULTRASOUND</b></p> <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 <p><b>MUSCULO-SKELETAL</b></p> <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	<p>POSSIBILITY OF PREGNANCY AND/OR BREASTFEEDING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>CARDIAC</b></p> <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) <p><b>NERVOUS</b></p> <input type="checkbox"/> BRAIN PERFUSION SPECT <p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> LIVER / SPLEEN (SULPHUR COLLOID) <input type="checkbox"/> R.B.C LIVER <input type="checkbox"/> HEPATOBIILIARY (HIDA) <input type="checkbox"/> GASTRIC EMPTYING <input type="checkbox"/> SALIVARY <p><b>SKELETAL</b></p> <input type="checkbox"/> BONE / WHOLE BODY <input type="checkbox"/> BONE (specify) _____ <p><b>ENDOCRINE</b></p> <input type="checkbox"/> THYROID UPTAKE & SCAN <input type="checkbox"/> PARATHYROID <p><b>RESPIRATORY</b></p> <input type="checkbox"/> VENTILATION/PERFUSION LUNG <p><b>GENITOURINARY</b></p> <input type="checkbox"/> RENAL FLOW & DIFFERENTIAL FUNCTIONAL (DTPA) <input type="checkbox"/> RENAL LASIX <input type="checkbox"/> RENAL CAPTOPRIL <p><b>OTHER NUCLEAR MEDICINE</b></p> <input type="checkbox"/> GALLUM (specify): _____ <input type="checkbox"/> SENTINEL NODE: _____ <input type="checkbox"/> OTHER (specify): _____
<b>ECHOCARDIOGRAPHY</b>	<b>BONE MINERAL DENSITY (BMD)</b>
<input type="checkbox"/> COMPLETE ECHO / DOPPLER STUDY OTHER _____ <b>Please include indication</b>	<input type="checkbox"/> HIGH RISK <input type="checkbox"/> LOW RISK Date of last exam _____ dd/mm/yyyy

MAMMOGRAPHY	XRAYS				
 <p style="text-align: center;">RIGHT LEFT</p> <p>Please indicate location and lesion</p> <input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> OBSP ROUTINE <input type="checkbox"/> MAMMOGRAM <input type="checkbox"/> IMPLANTS <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	<p><b>CHEST</b></p> <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 <p><b>ABDOMEN</b></p> <input type="checkbox"/> KUB <input type="checkbox"/> TWO VIEWS <p>OTHER _____</p>	<p><b>HEAD &amp; NECK</b></p> <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	<p><b>SPINE</b></p> <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-I JTS <p><b>SKELETAL SURVEY</b></p> <input type="checkbox"/> ARTHRITIC <input type="checkbox"/> METASTATIC <input type="checkbox"/> BONE AGE	<p><b>UPPER EXTREMITIES</b></p> <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	<p><b>LOWER EXTREMITIES</b></p> <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 – Nothing to eat or drink 4 hours (HIDA) Prep 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.