



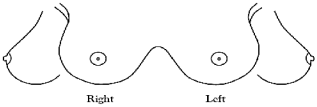
Premier Imaging

First in Patient Care | SINCE 1990

4289 Innes Road, Orleans, ON K1E 0A8
Telephone: (613) 686-1904 Fax: (613) 830-1902

Appointment: _____

Please arrive 15 minutes before your appointment and bring your OHIP card.
See reverse for preparatory instructions and location.

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|---|
| Patient's Last Name | | First Name | | DIGITAL ULTRASOUND (By appointment only) | | | |
| Address | | Date of Birth | | GENERAL | | MUSCULOSKELETAL | |
| City | Postal code | Phone # | | <input type="checkbox"/> Face | <input type="checkbox"/> Neck | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L |
| Health Card # | | Referral By | | <input type="checkbox"/> Abdominal wall | <input type="checkbox"/> Groin <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Testes/scrotum | <input type="checkbox"/> Soft tissue/superficial mass: |
| Address | | CC Reports to | | ABDOMEN & PELVIS | | | |
| DIGITAL X-RAY | | | | <input type="checkbox"/> Complete abdomen | | | |
| HEAD & NECK | | SPINE & PELVIS | | OBSTETRICAL | | | |
| <input type="checkbox"/> Soft tissue neck | <input type="checkbox"/> Skull | <input type="checkbox"/> Sinuses | <input type="checkbox"/> Orbits | <input type="checkbox"/> Facial bones | <input type="checkbox"/> Nasal bones | <input type="checkbox"/> Mandible | <input type="checkbox"/> T.M. joints |
| <input type="checkbox"/> Adenoids | ABDOMEN | | CHEST | | <input type="checkbox"/> OB dating <input type="checkbox"/> FTS/NT (11-14 weeks) <input type="checkbox"/> OB morphology (18-20 weeks) <input type="checkbox"/> OB growth <input type="checkbox"/> OB biophysical profile (BPP) <input type="checkbox"/> OB twin <input type="checkbox"/> Cervical length <input type="checkbox"/> Follicular monitoring | | |
| <input type="checkbox"/> Plain film (K.U.B.) | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Chest | <input type="checkbox"/> Ribs <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Sternum | | | |
| <input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> L/S spine <input type="checkbox"/> Sacrum & coccyx <input type="checkbox"/> S.I. Joints <input type="checkbox"/> Pelvis | | LOWER EXTREMITIES R L <input type="checkbox"/> Hip <input type="checkbox"/> Femur <input type="checkbox"/> Knee <input type="checkbox"/> Patella <input type="checkbox"/> Tibia & fibula <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Calcaneus <input type="checkbox"/> Toes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 | | OBSTETRICAL | | | |
| | | | | ARTERIAL DOPPLER | | | |
| UPPER EXTREMITIES R L <input type="checkbox"/> Shoulder <input type="checkbox"/> Clavicle <input type="checkbox"/> S.C. joints <input type="checkbox"/> A.C. Joints <input type="checkbox"/> Scapula <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Scaphoid <input type="checkbox"/> Hand <input type="checkbox"/> Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 | | SKELETAL SURVEY <input type="checkbox"/> Metastatic series <input type="checkbox"/> Scoliosis series | | VENOUS DOPPLER | | | |
| | | | | OTHER | | | |
| <input type="checkbox"/> _____ <input type="checkbox"/> _____ | | | | OTHER | | | |
| | | | | <input type="checkbox"/> _____ | | | |
| BONE MINERAL DENSITOMETRY (By appointment only) | | | | | | | |
| <input type="checkbox"/> Baseline (first BMD) <input type="checkbox"/> 3 yr-first follow up <input type="checkbox"/> High risk (1 year) <input type="checkbox"/> Low risk (5 year) | | | | | | | |
| DIGITAL MAMMOGRAPHY (By appointment only) | | | | | | | |
| <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other : _____ | | | |  | | | |
| Clinical History (REQUIRED) | | | | Date: ____/____/____ | | <input type="checkbox"/> STAT | |
| | | | | Physician's Signature: | | | |

1 This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: <http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx>.

GYNECOLOGY AND PELVIC EXAMINATION

- **A full bladder is required for men and not sexually active women.** If the bladder is **not** full at the time of your examination, a new appointment may have to be made.
- Drink at least 16 oz or 500 ml of water. You must be **finished** drinking at least **1 hour** prior to the examination.
- Allow a total time of 30 minutes for your examination.

VASCULAR AND MUSCULOSKELETAL ULTRASOUND

- No preparation is required.
- Allow a total time of 45 minutes to 1 hour for your examination.

OBSTETRICS

- **A full bladder is required.** If the bladder is **not** full at the time of your examination, a new appointment will have to be made.
- For the 1st and 2nd trimester, you must drink at least 16 oz or 500 ml of water. You must be **finished** drinking at least **1 hour** prior to the examination.
- Please note that it is the policy of this clinic to only provide a picture when requested. Video copies will not be provided.
- Allow a total time of 30 to 45 minutes for your examination.

BONE MINERAL DENSITY

- Allow a total time of 20 minutes for your examination.

MAMMOGRAPHY

- No antiperspirant.
- Allow a total time of 20 minutes for your examination.

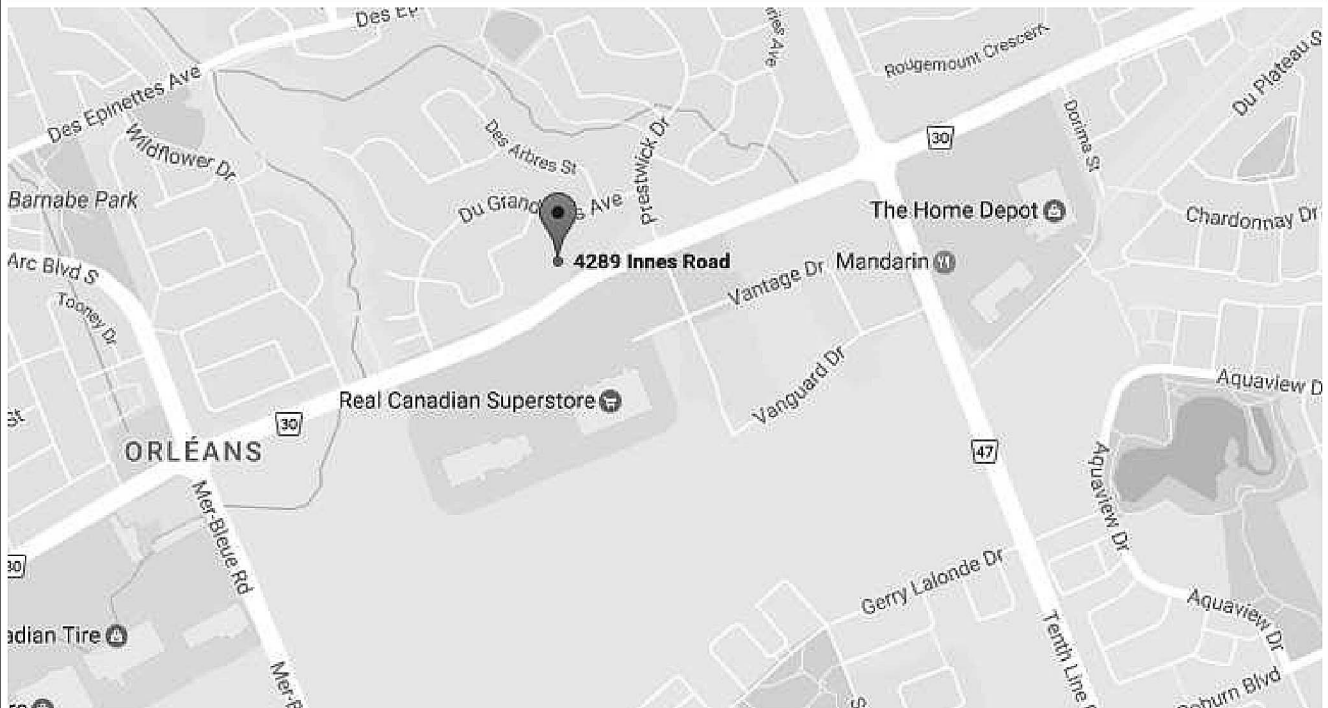
ABDOMEN

- **Morning appointment:**
Do not eat or drink from midnight.
- **Afternoon appointment:**
Do not eat or drink for 6 hours prior to the examination.
- Allow a total time of 30 minutes for your examination.

COMMENTS

- If you are unable to keep your appointment, please call 24 hours prior to advise.
- Please no perfume/cologne due to allergies.
- If children must accompany you for the visit, please ensure proper supervision.

LOCATION



DO NOT DISCONTINUE ESSENTIAL MEDICATION