

**PATIENT INFORMATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ TOWN/CITY \_\_\_\_\_ POSTAL \_\_\_\_\_  
PHONE ( ) \_\_\_\_\_ HEALTH CARD # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ VERSION \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ DAY MONTH YEAR  Male  Female

**APPOINTMENT DATE / TIME**

APPT. DATE \_\_\_\_\_ DAY MONTH YEAR  
APPT. DAY (please circle the day):  
**MON TUE WED THU FRI SAT**  
APPT. TIME \_\_\_\_\_  
\* Please provide 48 hours notice of cancellation.  
\$50 fee may be charged for missed appointment with no notice.

**X-RAY**

\* appointment or walk-in service may be available depending on site and day, no preparation required

\* please advise staff if you are or may be pregnant

**HEAD + NECK**

- Sinuses
- Skull
- Facial Bones
- Nose
- Mandible
- TM Joints
- Adenoids
- Neck for Soft Tissue
- Orbits
- Orbits - Pre-MRI

**ABDOMINAL**

- KUB (one view)
- Acute (two views) + PA Chest

**CHEST**

- Chest PA + LAT
- Chest PA Ins + Exp + Lat
- Sternum
- R Ribs + Chest PA
- L Ribs + Chest PA
- Immigration
- Chest PA

**SPINE + PELVIS**

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Sacrum + Coccyx
- S-I Joints
- Pelvis (one view)
- R Hip + Pelvis
- L Hip + Pelvis
- Scoliosis Series

**SKELETAL SURVEY**

- Arthritic (appt. preferred)
- Metastatic (appt. preferred)
- Bone Age

**OTHER EXAMS OR VIEWS:**

**UPPER EXTREMITIES**

- R  L Shoulder
- R  L Clavicle
- Sternoclavicular Joints
- AC Joint
- R  L Scapula
- R  L Humerus
- R  L Elbow
- R  L Forearm
- R  L Wrist
- R  L Scaphoid
- R  L Hand
- R  L Digit



**LOWER EXTREMITIES**

- R  L Hip
- R  L Femur
- R  L Knee
- R  L Tibia + Fibula
- R  L Ankle
- R  L Foot
- R  L Calcaneus
- R  L Toes



**ULTRASOUND**

\* by appointment, and see preparations at back

**OBSTETRICAL**

- Complete Obstetrical (18-20W)
- Dating
- High Risk/Complications
- IPS (NT, 11-14W)
- Biophysical Profile

**PELVIC**

- Transabdominal
- Transvaginal
- 3D (IUD check / uterine shape)

**ABDOMINAL**

- Abdominal
- Abdomen + Pelvis
- Abdomen LIVER CLINIC
- Liver Elastography (non-OHIP)
- Intraabdominal Fat
- Abdominal Wall - Location:

**OTHER EXAMS:**

**PROSTATE (incl. kidneys + bladder)**

- Transabdominal
- Transrectal
- Transrectal+Uroflow

**SMALL PARTS**

- Thyroid  Neck
- Scrotum

**MUSCULOSKELETAL**

- R  L Shoulder
- R  L Elbow
- R  L Wrist
- R  L Hip
- R  L Knee
- R  L Ankle
- R  L Foot
- R  L Achilles/Plantar Fascia
- R  L Inguinal Hernia
- R  L Lumps/Masses

bilateral imaging suggested

**VASCULAR ULTRASOUND + CARDIAC TESTING**

\* by appointment, and see preparations at back

**HEAD + NECK**

- Arterial (Carotids + Vertebrals)
- Carotid Intimal Thickness

**ABDOMEN**

- Abdominal Aorta

**CARDIAC TESTING**

- Echocardiography
- LV function
- Chest Pain
- SOB
- Palp/Arrhythmia
- Syncope
- HTN
- CAD
- Murmur

**EXTREMITIES (Peripheral Venous)**

- Arm
- Leg: Superficial Venous/Reflux (Varicose Veins)
- Leg: Deep Venous Sys./Thrombosis (DVT)

**EXTREMITIES (Peripheral Arterial)**

- Arm  Leg
- with ankle-brachial indices

**Holter Indication List:**

- Screening
- Palpitations
- A-fib
- Syncope
- CVA
- Other:

**CLINICAL HISTORY REQUESTED**

- WSIB

- Interpretation of Chiropractic X-Rays Requested
- Consult requested for MRI/CT/Xray/Ultrasound

**BONE MINERAL DENSITY (DEXA)**

\* walk-ins welcome, appointment preferred

- BMD in accordance with Ministry of Health ordering guidelines



**BREAST IMAGING**

\* by appointment, and see preparations at back

Diagnostic Mammogram

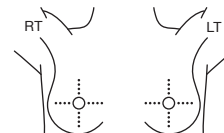
- Bilateral
- Right
- Left
- Implants

- Contact patient directly if more views required
- Contact patient directly to book breast biopsy if required
- OBSP Screening

Ultrasound

- Bilateral
- Right
- Left
- Implants

Other: \_\_\_\_\_  
Previous:  Yes  No



Where: \_\_\_\_\_  
When: \_\_\_\_\_



**REFERRING PHYSICIAN**  **STAT**  **VERBAL**

NAME OF DOCTOR \_\_\_\_\_ DOCTOR'S SIGNATURE \_\_\_\_\_

PHONE \_\_\_\_\_ FAX / EMERGENCY TEL. \_\_\_\_\_

DATE ISSUED: \_\_\_\_\_ DAY MONTH YEAR

- Request CD

**COPY TO:** \_\_\_\_\_ NAME \_\_\_\_\_ FAX # \_\_\_\_\_



## PATIENT PREPARATION INSTRUCTIONS

### ULTRASOUND PREPARATIONS

- ABDOMEN, ABDOMINAL AORTA, ELASTOGRAPHY**  
Avoid excess fats the night prior to the exam and solid foods 8 hours before the exam. Small quantities of clear fluids are permitted. (Any medication should be taken as required).  
  
上腹腔：检查前一夜避免进食过量脂肪。  
检查前的 8 小时内避免摄入固体食物。  
少量清流质食物尚可（应该根据医生嘱咐按时服用任何药物）
- PELVIC ONLY – FEMALE & MALE**  
One hour prior to exam, drink 4 cups of water (total 32 oz). Do NOT empty bladder.  
  
下腹腔 – 女性和男性  
检查前一小时饮四杯水（共 1000 毫升），但不可如厕。
- PROSTATE-TRANSRECTAL**  
The evening before the examination, take a fleet enema (purchased at the drug store). One hour prior to exam, drink 4 cups of water (total 32 oz). Do NOT empty bladder.  
  
前列腺-经直肠超声波检查  
请于检查前一晚使用灌肠剂（自行在药店购买）。  
检查前一小时，喝 4 杯水（共 1000 毫升），但不可如厕。
- ABDOMEN & PELVIC SAME VISIT**  
Avoid solid foods and excess fats 8 hours before the exam. Small quantities of clear fluids are permitted. One hour prior to exam drink 4 cups of water (total 32 oz). Do NOT empty bladder.  
  
上腹腔及下腹腔  
检查前的 8 小时内避免进食固体及过量脂肪。  
少量清流质食物尚可。检查前一小时，喝 4 杯水（共 1000 毫升），但不可如厕。
- PREGNANCY**  
One hour prior to the exam, drink the required amount of water:  

under 12 weeks	4 cups (32 oz)
12-24 weeks	3 cups (24 oz)
over 24 weeks	2 cups (16 oz)

  
验孕：检查前一小时按下列定量饮水：  

12 孕周以下	4 杯（共1000 毫升）
12 至 24 孕周	3 杯（共750 毫升）
24 孕周以上	2 杯（共500 毫升）
- ECHOCARDIOGRAM, SCROTUM, THYROID + NECK, PARATHYROID, SALIVARY GLANDS, MUSCULO-SKELETAL, VASCULAR ULTRASOUND**  
No preparation required.  
  
心脏超声波、阴囊、甲状腺和颈部、甲状旁腺、唾液腺、骨骼肌肉、以及血管超声等，以上检查不需要准备
- MAMMOGRAPHY**  
No powder or deodorant on day of your mammogram.  
  
乳腺钼靶 X 线摄影 - 检查当日请不要使用粉剂或除臭剂。
- BONE MINERAL DENSITY**  
No vitamins, no calcium or iron supplements on day of your exam.  
  
骨密度 - 检查当日请不要使用维生素或钙片。

### APPOINTMENTS

#### PLEASE FOLLOW PREPARATIONS CAREFULLY:

- We reserve the right to refuse and reschedule services due to circumstances such as arrival time, equipment downtime, patient/equipment weight capacities, etc.
- Please allow approx. 45 minutes for each exam.
- **Please arrive 10 minutes prior** to your scheduled appointment time in order to register and to complete any necessary paperwork.
- **48 hours notice is required for cancellations. \$50 fee may be charged for missed appointment with no notice.**
- Reports will be sent to the referring physician within 2-3 days. Urgent cases will be forwarded as soon as possible.
- Ministry of Health guidelines restrict the release of reports directly to patients.

#### 检查须知：

请在约定时间前 10 分钟到达，以便办理登记手续以及填写任何必要的表格。取消检查需要于 48 小时前通知。

### CLINIC LOCATIONS & NORMAL HOURS

Mon. to Thurs. 8:00am – 7:30pm	Friday 8:00am – 5:00pm	Saturday 8:00am – 1:00pm
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HOURS SUBJECT TO CHANGE, PLEASE CALL TO CONFIRM

**SHEPPARD SITE**

**ULTRASOUND ONLY**

Sheppard Ave. East

Bayview Ave.

BESSARION STATION

Bessarion Rd.

Leslie St.

Highway 401

**\*\* NEW \*\*  
LOCATION**

701 Sheppard Ave. East Unit #316, North York, ON, M2K 2Z3  
tel (416) 613-8678 fax (416) 309-1980

**FINCH SITE**

**ALL SERVICES AVAILABLE**

**FREE PARKING**

Steeles Ave. East

Kennedy Rd.

lane to parking

Midland Ave.

Brimley Rd.

McCowan Rd.

Finch Ave. East

4168 Finch Ave. East Unit #G18, Scarborough, ON, M1S 5H6  
tel (416) 293-5940 fax (416) 293-6036

**FAIRVIEW SITE**

**ALL SERVICES AVAILABLE**

Leslie St.

Don Mills Rd.

Fairview Mall Dr.

Fairview Mall

Don Valley Pkwy.

Fairview Mall Dr.

Sheppard Ave. East

5 Fairview Mall Drive Unit #100, North York, ON, M2J 2Z1  
tel (416) 499-3559 fax (416) 499-4631

Please only use 4190's parking lot if you are visiting the 4190 plaza, otherwise there is a risk of ticketing.