Tel: 905-546-5644
Fax: 905-546-5645
304 Victoria Avenue North, Suite 203
Hamilton, ON L8L 5G4

HAMILTON DIAGNOSTIC IMAGING

Please complete from and give to patient.
See back for patient instructions.

Please arrive 10 minutes before your exam appointment time.
Your health card and requisition are required for all visits.

PATIENT NAME: _____

PATIENT ADDRESS: _____ PATIENT PHONE #: _____

D.O.B: _____ HEALTHCARD #: _____ VC: _____

APPOINTMENT DATE: _____ TIME: _____

REFERRING PHYSICIAN NAME: _____ CC PHYSICIAN: _____

PHYSICIAN SIGNATURE: _____ BILLING # _____

PHYSICIAN PHONE #: _____ PHYSICIAN FAX #: _____

REASON FOR TEST: _____

ULTRASOUND

OBSTETRICAL
- ☐ EARLY, UNDER 16 WEEKS
- ☐ NUCHAL TRANSLUCENCY (11 TO 14 WEEKS)
- ☐ ROUTINE 18-20 WEEK ANATOMICAL ASSESSMENT (1 PER PREGNANCY)
- ☐ FETAL GROWTH ASSESSMENT
- ☐ BIOPHYSICAL PROFILE
- ☐ LIMITED (I.E.FETAL PRESENTATION)
- ☐ HIGH RISK / COMPLICATIONS

SMALL PARTS
- ☐ THYROID
- ☐ PAROTID
- ☐ SUBMANDIBULAR GLAND
- ☐ SOFT TISSUE FACE & NECK
- ☐ AXILLA (ONLY-EG LYMPH NODE) (R) (L)
- ☐ OTHER: _____

ABDOMEN/PELVIS
- ☐ ABDOMEN
- ☐ LIVER for Cirrhosis, Hep, HCC (incl. Portal Hypertension)
- ☐ ABDOMEN LTD - **SPECIFY:** _____
- ☐ VENOUS (DVT)
- ☐ AORTA / ILIAC ARTERIES (incl. AAA Screening)
- ☐ KIDNEYS, URETERS, BLADDER ☐ FEMALE ☐ MALE
- ☐ APPENDIX
- ☐ PELVIC ☐ FEMALE ☐ MALE
- ☐ TRANSVAGINAL
- ☐ SCROTUM
- ☐ HERNIA ASSESSMENT ☐ INGUINAL ☐ ABDOMINAL WALL

MUSCULOSKELETAL
- ☐ SHOULDER (R) (L)
- ☐ ELBOW (R) (L)
- ☐ WRIST (R) (L)
- ☐ HAND (R) (L)
- ☐ DIGIT # _____ (R) (L)
- ☐ ADULT HIP (R) (L)
- ☐ KNEE (R) (L)
- ☐ ACHILLES TENDON (R) (L)
- ☐ ANKLE (R) (L)
- ☐ PLANTAR FASCIA (R) (L)
- ☐ FOOT (R) (L)
- ☐ TOE # _____ (R) (L)
- ☐ LUMP/BUMP (R) (L)

☐ OTHER: _____

BREAST IMAGING

- ☐ BREAST ULTRASOUND (R) (L)
- ☐ SCREENING MAMMOGRAM (NON-OBSP)
- ☐ DIAGNOSTIC MAMMOGRAM (R) (L)

IMPLANTS ☐ YES ☐ NO

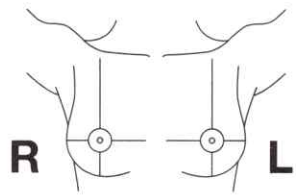
AND/OR CHECK REASON FOR TESTING:

☐ LUMP ☐ DISCHARGE ☐ PAIN ☐ SWELLING

☐ ADDITIONAL IMAGING IF TEST RESULT IS POSITIVE / ABNORMAL

ontario breast screening program
a cancer care ontario program

☐ OBSP - SCREENING MAMMOGRAM



Indicate area of concern on diagram

X-RAY (no appointment required)

CHEST
- ☐ CHEST P.A. & LAT.
- ☐ CHEST P.A.
- ☐ RIBS (R) (L)
- ☐ STERNUM
- ☐ STERNOCLAVICULAR JTS
- ☐ THORACIC INLET

ABDOMEN
- ☐ ABDOMEN - 1 view
- ☐ ABDOMEN - K.U.B. X-Ray
- ☐ ABDOMEN - ACUTE (2+v)

HEAD & NECK
- ☐ SKULL
- ☐ SINUSES *(MOH De-Listed)*
- ☐ FACIAL BONES
- ☐ NASAL BONES
- ☐ MANDIBLE
- ☐ ORBITS FOR MRI
- ☐ NECK FOR SOFT TISSUE
- ☐ OTHER: _____ _____

SPINE & PELVIS
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ SACRUM & COCCYX
- ☐ S.I. JOINTS
- ☐ PELVIS
- ☐ THORACOLUMBAR SPINE (SCOLIOSIS SERIES)

SKELETAL SURVEY
- ☐ ARTHRITIC
- ☐ METASTATIC

UPPER EXTREMITIES
- ☐ ACROMIOCLAVICULAR (A.C.) JOINTS
- ☐ CLAVICLE (R) (L)
- ☐ SCAPULA (R) (L)
- ☐ SHOULDER (R) (L)
- ☐ HUMERUS (R) (L)
- ☐ ELBOW (R) (L)
- ☐ FOREARM (R) (L)
- ☐ WRIST (R) (L)
- ☐ HAND (R) (L)
- ☐ DIGIT # _____ (R) (L)

LOWER EXTREMITIES
- ☐ HIP (R) (L)
- ☐ FEMUR (R) (L)
- ☐ KNEE (R) (L)
- ☐ TIBIA & FIBULA (R) (L)
- ☐ ANKLE (R) (L)
- ☐ CALCANEUS (R) (L)
- ☐ FOOT (R) (L)
- ☐ TOE # _____ (R) (L)

STAT ☐ : _____