Queensway X-ray & Ultrasound

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Suite 107-21 Queensway West, Mississauga, ON, L5B 1B6

• FREE PARKING • FEMALE TECHNOLOGISTS AVAILABLE • OPEN EVERYDAY

PLEASE BRING THIS FORM AND YOUR HEALTH CARD ON THE APPOINTMENT DATE

PATIENT LAST NAME	FIRST NAME	DATE
HEALTH CARD NUMBER	DATE OF BIRTH	TELEPHONE/CELL
PATIENT'S ADDRESS:		

Appointment Date & Time

Day_____

Date_____

Time_____

- **I DECLARE THAT I AM NOT CURRENTLY PREGNANT. (For X-Rays)**
- **24 hr notice required to cancel appointment or $40 charge**

Y I am able to come on short notice N

- I consent to appts, results status & referrals being disclosed by phone, text or e-mail provided.
- I Agree that it is my (patient) responsibility to follow up on test results with a physician in reasonable amount of time.

Signature: _____

BONE DENSITY

- ☐ Baseline
- ☐ First follow up-3yr
- ☐ Low Risk-5yr
- ☐ High Risk-1yr

BARIUMSTUDIES *(By Appt. Only)*

- ☐ Barium Swallow
- ☐ Upper G.I.
- ☐ Upper G.I.+Small Bowel
- ☐ Barium Enema Air Contrast

X-RAY *(No Appt. Required)*

SPINE & PELVIS

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ L/S Spine, Pelvis &S.I. Joints
- ☐ Lumbo-Sacral Spine
- ☐ Sacrum & Coccyx
- ☐ S.I. Joints
- ☐ AP Pelvis
- ☐ Pelvis & Hips
- ☐ Pelvis & L Hip
- ☐ Pelvis & R Hip
- ☐ Pelvis & S.I. Jts.

HEAD & NECK

- ☐ Skull
- ☐ Sinuses
- ☐ Soft Tissues of Neck
- ☐ Nasal Bones
- ☐ Facial Bones
- ☐ Mandible
- ☐ T.M. Joints
- ☐ Orbits
- ☐ Mastoids

ABDOMEN

- ☐ 3 Views
- ☐ Single view (KUB)

UPPER EXTREMITIES

- ☐L ☐R Shoulder
- ☐L ☐R Clavicle
- ☐L ☐R A.C. Joints
- ☐L ☐R Scapula
- ☐L ☐R Humerus
- ☐L ☐R Elbow
- ☐L ☐R Forearm
- ☐L ☐R Wrist & Scaphoid
- ☐L ☐R Wrist
- ☐L ☐R Scaphoid
- ☐L ☐R Hand
- ☐L ☐R Finger

N° 1 2 3 4 5

- ☐L ☐R Soft Tissue (upper extremity)

LOWER EXTREMITIES

- ☐L ☐R Hip
- ☐L ☐R Femur
- ☐L ☐R Knee
- ☐L ☐R Tib & Fib
- ☐L ☐R Ankle
- ☐L ☐R Foot
- ☐L ☐R Calcaneus
- ☐L ☐R Toes

N° 1 2 3 4 5

- ☐L ☐R Soft Tissue (lower extremity)

CHEST

- ☐ Chest (PA & Lat)
- ☐B ☐L ☐R Ribs
- ☐ Sternum
- ☐ S.C. Joints

Other tests

- ☐ _____

ULTRASOUND (By Appt. Only)

CHEST

- ☐ Wall Mass
- ☐ Pleural E.
- ☐ Aorta

NECK

- ☐ Neck & Face
- ☐ Thyroid
- ☐ Glands

- ☐ STAT

CLINICAL INFORMATION

MD: _____

Name Signature Billing#

By signing this, the physician confirms that they have educated the patient and it is totally the patient's responsibility to make sure they follow up with a physician for the results to the above tests.

This requisition form can be taken to any licensed facility providing diagnostic imaging services including hospitals and IHFs.

ULTRASOUND *(By Appt. Only)*

PELVIC

- ☐ **Abdomen & Pelvis** (includes transvaginal unless contraindicated)
- ☐ **Pelvis + TV complete** (unless contraindicated)
- ☐ **Pelvis complete**
- ☐ **Pelvis Limited**
  - ☐ Bladder
  - ☐ Prostate Transabdominal
  - ☐ Prostate Transrectal
- ☐ **Transvaginal**
- ☐ **Renal + Bladder**
- ☐ **PVR- Post Void Residual**
- ☐ **Testes/Scrotum**

PREGNANCY

- ☐ **OB Dating (< 16 wks)**
- ☐ **OB Routine (18-20 wks)**
- ☐ **OB Routine (> 20 wks)**
- ☐ **IPS/EFTS (NT) (11-13 wks, 6 days)**
- ☐ **OB High Risk**
- ☐ **Biophysical Profile (>30 wks)**
- ☐ **Fetal Position**

☐ BREAST

(B) ☐ **(L)** ☐ **(R)** ☐

ABDOMEN

- ☐ **Abdomen Complete**
- ☐ **Abdomen Limited**
  - ☐ Liver
  - ☐ Pancreas
  - ☐ Spleen
  - ☐ Abdominal aorta
  - ☐ Appendix
  - ☐ G.B. & Biliary system
  - ☐ Kidneys
- ☐ **Abdominal wall**
- ☐ **Inguinal Canal/ Hernia**
- ☐ **Groin**

MUSCULOSKELETAL

- ☐L ☐R **Hip**
- ☐L ☐R **Hamstring**
- ☐L ☐R **Knee**
- ☐L ☐R **Achilles Tendon**
- ☐L ☐R **Ankle**
- ☐L ☐R **Foot**
- ☐L ☐R **Shoulder**
- ☐L ☐R **Elbow**
- ☐L ☐R **Wrist**
- ☐L ☐R **Other**

Tech._____