WELL Health | DIAGNOSTIC CENTRES

REQUEST FOR EXAMINATION – SAULT STE. MARIE

The Doctor's Building
955 Queen Street East, Suite 50
Sault Ste. Marie, ON P6A 2C3
T: 705-759-1144 | F: 705-759-5978 | E: ssm_queen@welldiagnostics.ca

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Check if Applicable: ☐ URGENT

Full Name (Birth): _____

Preferred Full Name (If Different from Birth): _____

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Cell Phone: _____ Alt. Phone: _____

Date of Birth: _____

Health Card #: _____ Version: _____

Gender (Birth): _____ Preferred Gender (If Different from Birth): _____

Height (cm): _____ Weight (kg): _____

Reason for Referral:

CARDIOLOGY CONSULTATION

☐ First Available
☐ Consult if Test Result is Positive/Abnormal

Please Attach: Medications, Previous Tests, Family & Social History

CARDIOLOGY

☐ 12-Lead Electrocardiogram (Rest ECG)
☐ Holter Monitoring
- ○ 24 hrs ○ 48 hrs ○ 72 hrs
- ○ Other: _____

☐ 24hr BP Monitor (Not insured by OHIP)

☐ Echocardiogram (Colour Doppler)
- ○ Chest pain suspicious of CAD
- ○ CHF
- ○ Hypertension
- ○ Murmur
- ○ Other: _____
- ○ Syncope
- ○ Palpitations/ Arrhythmias

X-RAY (WALK-IN SERVICE)

ABDOMINAL
☐ Single/KUB
☐ Acute (includes PA chest)

CHEST
☐ Chest PA & LAT
☐ Ribs ○R ○L
☐ Sternum
☐ Chest Visa

HEAD & NECK
☐ Soft Tissue Neck
☐ Skull
☐ Sinuses (Not insured by OHIP)
☐ Facial Bones
☐ Nose
☐ Mandible
☐ Orbits
☐ T.M. Joints
☐ Adenoids

LOWER EXTREMITIES

R	L	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tib. & Fib.
☐	☐	Ankle
☐	☐	Foot
☐	☐	Calcaneus
☐	☐	Toe: 1 2 3 4 5

SPINE & PELVIS
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar (L/S) Spine
☐ Sacrum/Coccyx
☐ S.I. Joints
☐ Pelvis
☐ Scoliosis Series

UPPER EXTREMITIES

R	L	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	Sternoclavicular joints
☐	☐	A.C. Joint
☐	☐	Scapula
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Finger: 1 2 3 4 5

OTHER
☐ Leg Lengths
☐ Skeletal Survey
☐ Bone Age
☐ Indicate: _____

ULTRASOUND

GENERAL ULTRASOUND
☐ Abdomen + Pelvis (Incl. reproductive organs)
☐ Abdomen (Incl. limited bladder + lower quadrants, no reproductive organs)
☐ Kidneys*
☐ Bladder
☐ Hernia (specify site): _____
☐ Other: _____
*Baseline abdominal ultrasound may be performed

PELVIS
☐ Female Pelvis (Incl. Transvaginal)
☐ Male Pelvis (Excl. Transrectal)

OBSTETRICAL
EDC (Required): _____
☐ Dating (< 16 weeks)
☐ Prenatal Screening (IPS/eFTS 11-14 weeks)
☐ Anatomy (18-20 weeks)
☐ Dual Scan Series (NT scan 11-14 weeks + Anatomical 18-20 weeks)
☐ Fetal Growth (30+ weeks)
○ BPP ○ UA Doppler ○ MCA Doppler
☐ Biophysical Profile (BPP)
☐ Twin Series (> 18 weeks)
☐ Follicular Study

SMALL PARTS
☐ Salivary Glands
☐ Thyroid
☐ Chest
☐ Groin ○ R ○ L
☐ Inguinal Canal ○ R ○ L
☐ Testes/Scrotum
☐ Soft Tissue/Lump (specify site): _____

MUSCULOSKELETAL

R	L	
☐	☐	Shoulder
☐	☐	Elbow
☐	☐	Wrist
☐	☐	Hip
☐	☐	Hamstring
☐	☐	Knee
☐	☐	Ankle/Achilles Tendon/ Plantar Fascia **(circle one)**
☐	☐	Other: _____

VASCULAR

R	L	
☐	☐	Venous - Lower Extremity (DVT)
☐	☐	Venous - Upper Extremity (DVT)
☐	☐	Arterial - Lower Extremity (ABI)

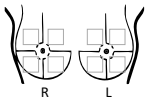
☐ Carotid
☐ Renal Arteries
☐ Portal Venous Doppler
☐ Aorta: _____

☐ **OTHER:** _____

BREAST ULTRASOUND

☐ Targeted Breast Ultrasound* ○ R ○ L (indicate quadrant on diagram)

*Breast ultrasound is not used for screening purposes. Mammogram/OBSP is recommended.



BONE MINERAL DENSITY

☐ Baseline ☐ Follow Up

REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)

Referring Provider: _____ (Print Name)

_____ (Signature)

Billing Provider #: _____

CPSO #: _____

Tel #: _____

Fax #: _____

Date: _____

Copy To: _____

Report Delivery Preference: ☐ Fax ☐ HRM ☐ Other: _____

Access your patient radiology reports at **WELLdiagnostics.ca/Access**

For location details, visit **WELLdiagnostics.ca/Locations**.
For test preparation, see the back of this form or visit **WELLdiagnostics.ca/Test-Prep**.

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REPORT ON BUSINESS

- Save a picture of your signed requisition and bring the original signed copy to your appointment.
- All our services require a scheduled appointment, except X-ray, which is provided on a walk-in basis.
- Please provide at least 24 hours' notice if you need to reschedule your appointment to avoid a no-show fee.
- We will send your diagnostic report to your referring healthcare provider who will follow-up with you. We can send it to additional healthcare providers upon your request.
- This requisition form can be submitted to any licensed Ontario healthcare facility, including hospitals and independent health facilities: health.gov.on.ca

ULTRASOUND

ABDOMEN: No eating or drinking (smoking or chewing gum) for 8 hours before your appointment.

PELVIC: You must completely drink 34 oz (or 1 litre) of water 1 hour before your appointment. **Do not empty your bladder before the examination.**

ABDOMEN & PELVIC: No eating or drinking for 8 hours before your appointment. HOWEVER, you must completely drink 34 oz (or 1 litre) of water 1 hour before your appointment. **Do not empty your bladder before the examination.**

OBSTETRIC: You must completely drink 34 oz (or 1 litre) of water 30 minutes before your appointment. **Do not empty your bladder before the examination.**

RENAL: No eating or drinking for 3 hours before your appointment.

RENAL & BLADDER: No eating or drinking for 2 hours before your appointment. Start drinking 34 oz (or 1 litre) of water 1.5 hours before your appointment and finish it 1 hour before your appointment. **Do not empty your bladder before the examination.**

OTHER: No preparation required for the following exams: Thyroid, Breast, Scrotum, Extremity and Vascular Ultrasound.

BONE MINERAL DENSITY

Do not take calcium/vitamin supplements 24 hours prior to exam. If you have had a nuclear medicine dye injection or a barium study within 2 weeks, please reschedule your BMD test. Patients are asked to wear clothing without zippers or metal attachments. **PLEASE DO NOT WEAR ANY SCENTED PRODUCTS.**

ULTRASOUND (CHILDREN AGES 0-17 YEARS)

ABDOMEN:
- **Under 2 Years:** No eating or drinking (except water) for 2 hours before your appointment.
- **Ages 2-4 Years:** No eating or drinking (except water) for 4 hours before your appointment.
- **Ages 5-12 Years:** No eating or drinking (except water) for 6 hours before your appointment.

PELVIC:
- **Under 3 Years:** Drink clear fluid without bubbles (such as water, apple juice, etc.).
- **Ages 3-6 Years:** Drink 16 oz. (2 cups) of water 30 minutes before your appointment.
- **Ages 7-11 Years:** Drink 24 oz. (3 cups) of water 45 minutes before your appointment.
- **Ages 12-17 Years:** Drink 32 oz. (4 cups) of water 1 hour before your appointment.

CARDIOLOGY CONSULTATION

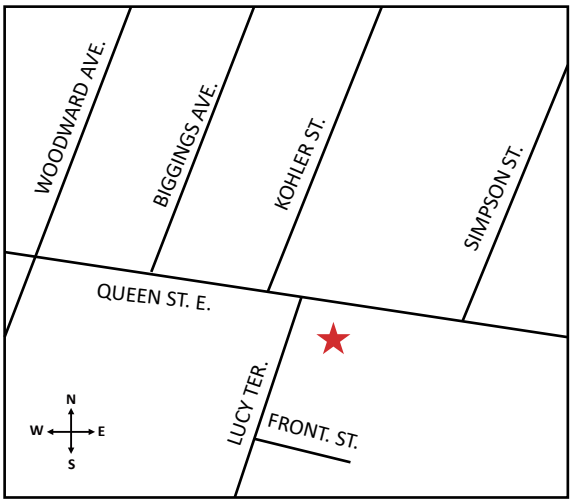
Please have a list of all your current medications with you before your appointment.

CARDIOLOGY

ECHOCARDIOGRAPHY: A cool sensation may be felt on the skin from the gel on the transducer, and a slight pressure of the transducer may be felt on your chest.

HOLTER MONITORING: Please do not put any cream/lotion on your chest. Wear loose, comfortable clothing. Bring a list of all your current medications. Please note: a shower/bath is not permitted during the recording period.

BLOOD PRESSURE MONITORING: Please wear a shirt/blouse with short or loose fitting sleeves. Bring a list of all your current medications.



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For Northern Health Travel Grant: www.health.gov.on.ca/en/public/publications/ohip/northern.aspx

This requisition form can be submitted to any licensed Ontario healthcare facility, including hospitals and independent health facilities, such as those listed here: www.health.gov.on.ca