WELL Health | DIAGNOSTIC CENTRES

REQUEST FOR EXAMINATION – SUDBURY RADIOLOGY

☐ Sudbury Elm
40 Elm Street, Suite 255
T: 705-673-2565 | F: 705-673-4482

☐ Sudbury Lasalle
1122 Lasalle Boulevard, Suite 107
T: 705-560-1114 | F: 705-560-7191

☐ Sudbury Long Lake
2009 Long Lake Road, Suite 103
T: 705-523-1295 | F: 705-523-2012

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Check if Applicable: ☐ URGENT ☐ WSIB

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:

X-RAY (WALK-IN SERVICE)

ABDOMINAL
- ☐ Single/KUB
- ☐ Acute (Incl. 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
- ☐ NEJAC Protocol
- ☐ Indicate: _____

NUCLEAR CARDIOLOGY (SUDBURY ELM)

MYOCARDIAL PERFUSION
- ☐ Exercise
- ☐ Persantine

BONE MINERAL DENSITY (SUDBURY ELM)

- ☐ Baseline
- ☐ Follow Up

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

MUSCULOSKELETAL

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

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

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) - **Sudbury Elm**
- ☐ Follicular Study

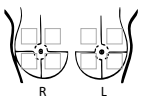
VASCULAR

R L
- ☐ ☐ Venous - Lower Extremity (DVT)
- ☐ ☐ Venous - Upper Extremity (DVT)
- ☐ ☐ Arterial - Lower Extremity (ABI)
- ☐ ☐ Arterial - Upper Extremity
- ☐ Carotid
- ☐ Renal Arteries
- ☐ Portal Venous Doppler
- ☐ Aorta: _____

US GUIDED PROCEDURES
- ☐ Biopsy - Thyroid FNA - **Sudbury Elm**
- ☐ **OTHER:** _____

MAMMOGRAPHY & WOMEN'S IMAGING

- ☐ Targeted Breast Ultrasound* (indicate quadrant on diagram): ○ R ○ L
- ☐ Mammogram: ○ R ○ L ○ Implants
- ☐ Mammogram & Bone Mineral Density: ○ R ○ L ○ Implants | ○ Baseline ○ Follow Up



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

REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)

Referring Provider (Print Name): _____ Billing Provider #: _____ CPSO #: _____

Tel #: _____ Fax #: _____

Date: _____ Copy To: _____

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

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

Referring Provider Signature:

For location details, visit **WELLdiagnostics.ca/Locations**

For test preparation, visit **WELLdiagnostics.ca/Test-Prep**