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 (Incl. limited bladder + lower quadrants, no reproductive organs)
☐ Abdomen + Pelvis (Incl. reproductive organs)
☐ Female Pelvis (Incl. Transvaginal)
☐ Male Pelvis (Excl. Transrectal)
☐ Abdominal Aorta (including AAA Screen)
☐ Kidneys*
☐ Bladder*
☐ Hernia: ○ Inguinal ○ Abdominal
☐ Other: _____

*Baseline abdominal ultrasound may be performed

OBSTETRICAL
EDC (Required): _____
☐ OB Series - Dating, Prenatal Screening, Anatomy
☐ Dating (< 16 weeks)
☐ Prenatal Screening (IPS/eFTS 11-13 weeks)
☐ Anatomy (18-20 weeks)
☐ Fetal Growth (30+ weeks):
○ BPP ○ UA Doppler ○ MCA Doppler
☐ Follicle Monitoring

☐ **OTHER:** _____

MUSCULOSKELETAL

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

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

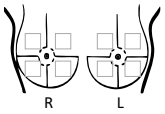
VASCULAR

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

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**.

ACCREDITED WITH EXEMPLARY STANDING — ACCREDITATION AGRÉMENT CANADA

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Important Information for Patients:

1. All services require an appointment, except X-ray, which is provided on a walk-in basis at select locations.
2. Minimum 24 hours' notice is required for all appointment changes to avoid a cancellation fee.
3. Ensure you are properly prepared for your appointment by reviewing our instructions at **WELLdiagnostics.ca/test-prep**.
4. We will send the report to your referring healthcare provider – all results must be discussed with your referring practitioner. We can send it to additional healthcare providers upon your request.

This requisition form can be submitted to any licensed Ontario imaging facility, including hospitals and Integrated Community Health Services Centres: Health.gov.on.ca
Northern Health Travel Grant: Health.gov.on.ca/en/public/publications/ohip/northern.aspx

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

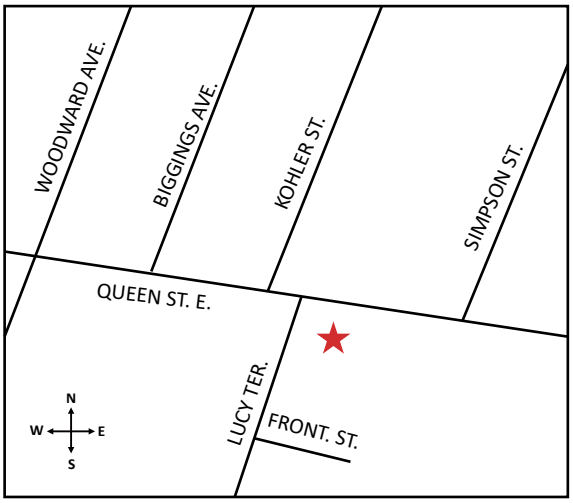
Please have a list of all your current medications with you before your appointment.

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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