

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Check if Applicable: **URGENT**

Full Name (Printed On Health Card): _____

Preferred Full Name (If Different Than Above): _____

Date of Birth: _____

Health Card #: _____ Version: _____

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

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

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Cell Phone: _____ Alt. Phone: _____

Reason for Referral: _____

CARDIOLOGY CONSULTATION

First Available
 Consult if Test Result is Positive/Abnormal


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

CARDIOLOGY

| | |
|--|---|
| <input type="checkbox"/> 12-Lead Electrocardiogram (Rest ECG) | <input type="checkbox"/> Echocardiogram (Colour Doppler): |
| <input type="checkbox"/> Holter Monitoring: | <input type="checkbox"/> Chest pain suspicious of CAD |
| <input type="radio"/> 24 hrs <input type="radio"/> 48 hrs <input type="radio"/> 72 hrs | <input type="radio"/> CHF <input type="radio"/> Syncope |
| <input type="radio"/> Other: _____ | <input type="radio"/> Hypertension <input type="radio"/> Palpitations/Arrhythmias |
| <input type="checkbox"/> 24hr BP Monitor (Not insured by OHIP) | <input type="radio"/> Murmur <input type="radio"/> Other: _____ |

X-RAY (WALK-IN SERVICE)

| | | |
|--|---|--|
| ABDOMINAL | LOWER EXTREMITIES | UPPER EXTREMITIES |
| <input type="checkbox"/> Single/KUB | R L | R L |
| <input type="checkbox"/> Acute (includes PA chest) | <input type="checkbox"/> Hip | <input type="checkbox"/> Shoulder |
| CHEST | <input type="checkbox"/> Femur | <input type="checkbox"/> Clavicle |
| <input type="checkbox"/> Chest PA & LAT | <input type="checkbox"/> Knee | <input type="checkbox"/> Sternoclavicular joints |
| <input type="checkbox"/> Ribs: <input type="radio"/> R <input type="radio"/> L | <input type="checkbox"/> Tib. & Fib. | <input type="checkbox"/> A.C. Joint |
| <input type="checkbox"/> Sternum | <input type="checkbox"/> Ankle | <input type="checkbox"/> Scapula |
| <input type="checkbox"/> Immigration Chest (Not insured by OHIP) | <input type="checkbox"/> Foot | <input type="checkbox"/> Humerus |
| HEAD & NECK | <input type="checkbox"/> Calcaneus | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Toe: 1 2 3 4 5 | <input type="checkbox"/> Forearm |
| <input type="checkbox"/> Skull | SPINE & PELVIS | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Sinuses (Not insured by OHIP) | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Scaphoid |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Hand |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Lumbar (L/S) Spine | <input type="checkbox"/> Finger: 1 2 3 4 5 |
| <input type="checkbox"/> Mandible | <input type="checkbox"/> Sacrum/Coccyx | OTHER |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> S.I. Joints | <input type="checkbox"/> Leg Lengths |
| <input type="checkbox"/> T.M. Joints | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Skeletal Survey |
| <input type="checkbox"/> Adenoids | <input type="checkbox"/> Scoliosis Series | <input type="checkbox"/> Bone Age |
| | | <input type="checkbox"/> Indicate: _____ |

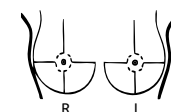


ULTRASOUND

| | |
|--|--|
| GENERAL ULTRASOUND | MUSCULOSKELETAL |
| <input type="checkbox"/> Abdomen (Incl. limited bladder + lower quadrants, no reproductive organs) | R L |
| <input type="checkbox"/> Abdomen + Pelvis (Incl. reproductive organs) | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Female Pelvis (Incl. Transvaginal) | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Male Pelvis (Excl. Transrectal) | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Screening Abdominal Aortic Aneurysm | <input type="checkbox"/> Hip (Bursitis) |
| <input type="checkbox"/> Renal* | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Bladder* | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Hernia: <input type="radio"/> Inguinal <input type="radio"/> Abdominal | <input type="checkbox"/> Achilles Tendon |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Plantar Fascia |
| | <input type="checkbox"/> Other: _____ |
| *Baseline abdominal ultrasound may be performed | |
| OBSTETRICAL | SMALL PARTS |
| EDC (Required): _____ | <input type="checkbox"/> Salivary Glands |
| <input type="checkbox"/> OB Series - Dating, Prenatal Screening, Anatomy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Dating (< 16 weeks) | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Prenatal Screening (IPS/eFTS 11-13 weeks) | <input type="checkbox"/> Groin: <input type="radio"/> R <input type="radio"/> L |
| <input type="checkbox"/> Anatomy (18-20 weeks) | <input type="checkbox"/> Inguinal Canal: <input type="radio"/> R <input type="radio"/> L |
| <input type="checkbox"/> Fetal Growth (30+ weeks): | <input type="checkbox"/> Testes/Scrotum |
| <input type="radio"/> BPP <input type="radio"/> UA Doppler <input type="radio"/> MCA Doppler | <input type="checkbox"/> Soft Tissue/Lump (specify site): _____ |
| <input type="checkbox"/> Follicle Monitoring | VASCULAR |
| <input type="checkbox"/> OTHER: _____ | R L |
| | <input type="checkbox"/> Venous - Lower Extremity (DVT) |
| | <input type="checkbox"/> Venous - Upper Extremity (DVT) |
| | <input type="checkbox"/> Arterial - Lower Extremity (ABI) |
| | <input type="checkbox"/> Carotid |
| | <input type="checkbox"/> Renal Arteries |
| | <input type="checkbox"/> Portal Venous Doppler |
| | <input type="checkbox"/> Aorta: _____ |

BREAST ULTRASOUND

Targeted Breast Ultrasound: R L (indicate quadrant on diagram)



BONE MINERAL DENSITY

Baseline
 Follow Up:
 High Risk/Medically Necessary
 Low/Medium Risk

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

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

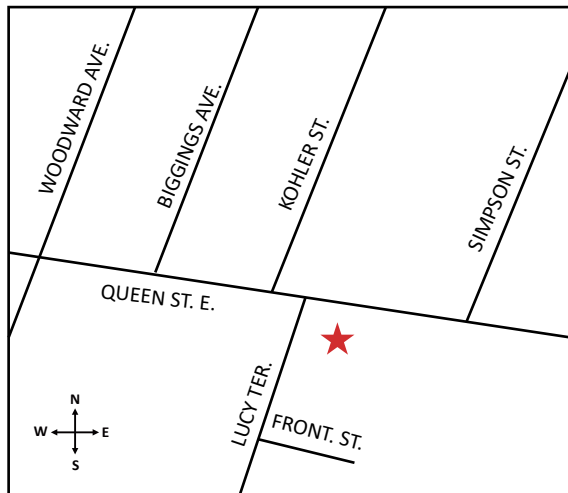
Please have a list of all your current medications with you before your appointment.

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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