

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Check if Applicable: **URGENT** WSIB

Full Name (Printed on Health Card): _____ Preferred Full Name (If Different Than Health Card): _____

Date of Birth: _____ Health Card #: _____ Version: _____

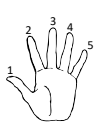
Gender (Birth): _____ Preferred Gender (If Different from Birth): _____ Height (cm): _____ Weight (kg): _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Cell Phone: _____ Alt. Phone: _____

Reason for Referral: _____

X-RAY (WALK-IN SERVICE)

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

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

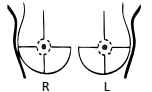
MYOCARDIAL PERFUSION

 Exercise
 Persantine

BONE MINERAL DENSITY (SUDBURY ELM)

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

MAMMOGRAPHY & BREAST IMAGING (SUDBURY ELM)

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


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: _____

