

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: _____

ULTRASOUND (SUITE C-100)

GENERAL ULTRASOUND

Abdomen (Incl. limited bladder + lower quadrants, no reproductive organs)

Abdomen + Pelvis (Incl. reproductive organs)

Female Pelvis (Incl. Transvaginal)

Male Pelvis (Excl. Transrectal)

Screening Abdominal Aortic Aneurysm

Renal*

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

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)

Venous - Lower Extremity (Reflux)

Arterial - Lower Extremity (ABI)

Arterial - Upper Extremity

Carotid

Renal Arteries

Portal Venous Doppler

Aorta: _____

CARDIOLOGY CONSULTATION (SUITE 200)

First Available

Consult if Test Result is Positive/Abnormal

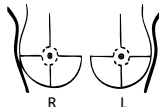
Please Attach: Medications, Previous Tests, Family & Social History

CARDIOLOGY (SUITE 200)

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

BREAST ULTRASOUND (SUITE C-100)

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



NUCLEAR CARDIOLOGY (SUITE C-100)

MYOCARDIAL PERFUSION

Exercise Persantine Dobutamine

REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)

Referring Provider: _____ (Print Name)

 (Signature)

Billing Provider #: _____

CPSO #: _____

Tel #: _____

Fax #: _____

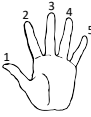
Date: _____

Copy To: _____

Report Delivery Preference: Fax HRM Other: _____

X-RAY (WALK-IN SERVICE – SUITE C-100)

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



Important Information for Patients:

- All our services require a scheduled appointment, except X-ray, which is provided on a walk-in basis at select locations.
- Minimum 24 hours' notice is required for all appointment changes to avoid a cancellation fee.
- Ensure you are properly prepared for your appointment by reviewing our instructions at WELldiagnostics.ca/test-prep.
- We will send the report to your referring healthcare provider who will contact you to review your results. 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

CARDIOLOGY

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

CARDIOLOGY CONSULTATION: Bring a list of all your current medications.

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.

EXERCISE STRESS TEST: Discontinue erectile dysfunction medication for 1 week before your test. Bring a list of all your current medications.

Wear soft sole shoes and comfortable clothing. Test time: Approximately 30 minutes

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.

MYOCARDIAL PERFUSION: No caffeine or decaf. for 12 hours; Clear fluids only for 4 hours prior to test on both days; Diabetic patients may have a light meal 2 hours prior to test; No powder or cream on skin; Off erectile dysfunction medications for 48 hours.

Exercise: Off Beta-Blockers for 48 hours (only if instructed by doctor)

Persantine: Off Theodur/Theophylline for 48 hours (only if instructed by doctor)

Time: Day 1 – 2 hours, Day 2 – 1 hour

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.

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.

TORONTO KING CARDIOLOGY

RSM Place
11 King Street West, Suite 200
Toronto, ON M5H 4C7
Enter RSM Place and take elevator up to the second floor, suite 200.

T: 416-324-4466 | F: 647-925-4618

SERVICES: Blood Pressure Monitoring, Consultations, Echocardiography, Electrocardiography, Exercise Stress Testing, Holter Monitoring

TORONTO KING RADIOLOGY

RSM Place
11 King Street West, Underground PATH, Suite C-100
Toronto, ON M5H 4C7
Enter RSM Place and take elevator down to underground PATH, suite C-100.

T: 416-864-1814 | F: 416-864-1499

E: toronto_king@welldiagnostics.ca

SERVICES: Blood Pressure Monitoring, Consultations, Echocardiography, Electrocardiography, Exercise Stress Testing, Holter Monitoring, Nuclear Stress Testing, Ultrasound, X-ray