

PATIENT INFORMATION:

PATIENT'S NAME: _____ D.O.B: _____ F M

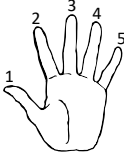
ADDRESS: _____

TELEPHONE #: _____ OHIP #: _____

APPOINTMENT DATE: _____ TIME: _____ LMP: _____ WEIGHT: _____

*Note: Please see back for patient instructions

Check if applicable **STAT**

NUCLEAR CARDIOLOGY	X-RAY (No Appointment)	
<input type="checkbox"/> MYOCARDIAL PERFUSION IMAGING (MPI) with ventricular function <input type="checkbox"/> Exercise <input type="checkbox"/> Persantine <input type="checkbox"/> Dobutamine <input type="checkbox"/> MYOCARDIAL WALL MOTION (MUGA) with ejection fraction <input type="checkbox"/> MYOCARDIAL VIABILITY STUDY (THALLIUM) Note: Please consult your doctor regarding discontinuation of Beta Blockers (48hrs), Erectile Dysfunction medications (48hrs), and Calcium Blockers (24hrs) prior to cardiac stressing.	HEAD & NECK <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Mastoids <input type="checkbox"/> Nose <input type="checkbox"/> Mandible <input type="checkbox"/> Orbits <input type="checkbox"/> Adenoids / Soft Tissue <input type="checkbox"/> TMJ - Temporomandibular Jt CHEST <input type="checkbox"/> Chest PA & LAT <input type="checkbox"/> Ribs <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Sternoclavicular Joints <input type="checkbox"/> Sternum <input type="checkbox"/> Other: _____ ABDOMINAL <input type="checkbox"/> Single / KUB <input type="checkbox"/> Acute (includes PA chest)	SPINE & PELVIS <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 LOWER EXTREMITIES R L <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"/> Heel <input type="checkbox"/> Toe: 1 2 3 4 5 <input type="checkbox"/> Skeletal Survey <input type="checkbox"/> OTHER X-RAY: _____
CARDIOLOGY	ULTRASOUND (By Appointment)	
<input type="checkbox"/> 12-LEAD ELECTROCARDIOGRAM (ECG) <input type="checkbox"/> ECHOCARDIOGRAM (COLOUR DOPPLER) <i>Please select one of the following indications:</i> <input type="checkbox"/> Chest pain suspicious of CAD <input type="checkbox"/> Murmur <input type="checkbox"/> Hypertension <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Palpitations / arrhythmias <input type="checkbox"/> Syncope <input type="checkbox"/> Other: _____ <input type="checkbox"/> EXERCISE STRESS TEST (TREADMILL) <input type="checkbox"/> HOLTER MONITORING A. <input type="checkbox"/> 24 hrs B. <input type="checkbox"/> 48 hrs C. <input type="checkbox"/> 72 hrs D. <input type="checkbox"/> 2 wks <input type="checkbox"/> 24HR BP MONITOR (\$80.00 fee required)	<input type="checkbox"/> OB U/S for dating (<i>less than 16 weeks</i>) <input type="checkbox"/> Bladder <input type="checkbox"/> OB U/S ROUTINE (<i>18 - 20 weeks</i>) <input type="checkbox"/> Pelvis (<i>to include transvaginal if appropriate</i>) <input type="checkbox"/> OB U/S NON-ROUTINE <input type="checkbox"/> Scrotal / Testicular <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> IPS (<i>between 11 to 13 weeks</i>) <input type="checkbox"/> Popliteal Fossa <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Abdomen <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Kidney <input type="checkbox"/> Aorta Only <input type="checkbox"/> MSK: _____ <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Thyroid <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Other: _____	
CARDIAC CONSULTATION	CARDIO-PULMONARY	
<input type="checkbox"/> CONSULTATION REQUESTED <input type="checkbox"/> Urgent, first available cardiologist <input type="checkbox"/> Dr. _____ <input type="checkbox"/> CONSULT IF TEST RESULT IS POSITIVE / ABNORMAL	<input type="checkbox"/> Pre & Post Spirometry <input type="checkbox"/> Full Pulmonary Function Test <input type="checkbox"/> Include Respirology Consult	
GENERAL NUCLEAR MEDICINE	BONE MINERAL DENSITY	
BONE SCAN <input type="checkbox"/> Whole Body <input type="checkbox"/> Specific Site: _____ ENDOCRINE <input type="checkbox"/> Thyroid <input type="checkbox"/> Parathyroid <i>Indication for ordering thyroid scan:</i> <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Other: _____ PULMONARY <input type="checkbox"/> V/Q Lung Scan	GASTROINTESTINAL <input type="checkbox"/> Gastric Emptying Scan <input type="checkbox"/> Biliary Scan <input type="checkbox"/> Liver / Spleen Scan <input type="checkbox"/> Hemangioma Scan <input type="checkbox"/> G.I. Bleeding Scan <input type="checkbox"/> Meckel's Scan INFECTON OR TUMOR <input type="checkbox"/> Gallium Scan	RENAL <input type="checkbox"/> Captopril Renal <input type="checkbox"/> Lasix Renal <input type="checkbox"/> Renal Function MISCELLANEOUS <input type="checkbox"/> Lacrimal Scan <input type="checkbox"/> Salivary Scan <input type="checkbox"/> Testicular Scan <input type="checkbox"/> Sentinel Node Scan
		

Clinical Information: _____

Referring Physician: _____ Print Name _____ Signature _____ Fax #: _____

Copy To: _____ Print Name _____ Fax #: _____

PATIENT PREPARATION AND INSTRUCTIONS

NOTES:

1. A valid health card must be shown at every visit.
2. A signed requisition by a registered physician is mandatory for all exams.
3. If you would like to cancel/ change your appointment, please notify our office at least 24 hours prior to your scheduled time.

For additional locations across Ontario, visit www.myhealthcentre.ca

NUCLEAR CARDIOLOGY

1. Patient may have a light breakfast/lunch (e.g. toast, jam, fruit, juice, water) and then nothing to eat 1 hour prior to the test.
2. Discontinue all caffeine products 24 hours prior to the test. This includes all tea, coffee, decaffeinated tea/coffee, pop, chocolate, Tylenol 2 & 3 and/or medications containing caffeine.
3. Insulin-dependent diabetics should take their insulin and a light meal 1 hour prior to the test.
4. Wear loose fitting clothing (e.g. T-shirt, track pants, athletic shoes, etc.).
5. Bring a list of all current prescription medications and check with your physician regarding the discontinuation of any heart medications (e.g. Beta-Blockers like Metoprolol or Atenolol, as well as Calcium Channel Blockers like Diltiazem or Verapamil).
6. Do not take erectile dysfunction medications (e.g. Viagra, Cialis, Levitra, etc.) 48 hours prior to the test.

MYOCARDIAL PERFUSION IMAGING consists of 2 parts: 1. Rest Study - takes approximately 1.5 - 2 hours and consists of an injection followed by imaging. 2. Stress Study - takes approximately 2 - 2.5 hours and consists of a stress test, injection and imaging.

ULTRASOUND

ABDOMEN

No eating or drinking (smoking or chewing gum) 8 hours prior to appointment.

ABDOMEN / PELVIS

No eating or drinking 8 hours prior to appointment EXCEPT that you must drink 34 oz or 1 litre of water FINISHED 1 hour prior to appointment.

Do not empty bladder before examination.

OBSTETRICS / PELVIS

Drink 34 oz or 1 litre of water 1 hour prior to appointment.

Do not empty bladder before examination.

OTHER

No preparation required for the following exams: Thyroid, Breast, Scrotum, Extremity and Vascular Ultrasound.

BONE SCAN

You will receive an injection. After the injection, you will be free to go until your next appointment time. You will be instructed to drink 3-4 glasses of fluids and void frequently. You will return at the second appointment time for pictures.

Initial Injection: 20 min

Later Images: 1 hour

PULMONARY FUNCTION / PRE & POST SPIROMETRY

Discontinue bronchodilators: Ventolin, Salbutamol, Advair and Symbicort for 12 hours. Spiriva for 24 hours. If you feel you must take the bronchodilator, do so, but call the clinic to rebook your test date.

No smoking 24 hours prior to the test. Please note the time of your last cigarette.

CARDIOLOGY

EXERCISE STRESS TEST

Erectile Dysfunction medication should be discontinued for 1 week prior to test. Bring your list of medications with you.

Wear soft sole shoes and comfortable clothing.

Total test time: Approximately 30 minutes.

HOLTER MONITORING OR EVENT RECORDING

Please do not put any cream/lotion on your chest.

Wear loose, comfortable clothing. Bring current list of medications. Please note no shower/bath is permitted during recording period.

BLOOD PRESSURE MONITORING

Please wear blouse/shirt with short or loose fitting sleeves.

Bring current list of medications.

BONE MINERAL DENSITY (BMD)

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.