

PATIENT INFORMATION:

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

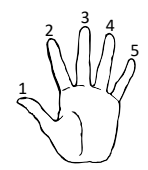
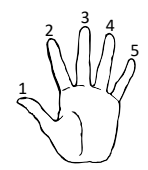
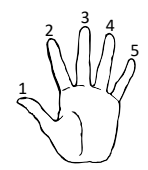
ADDRESS: _____

TELEPHONE #: _____ OHIP #: _____

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

*Note: Please see back for patient instructions and directions

 Check if applicable **STAT**

<div style="background-color: #c00000; color: white; text-align: center; padding: 2px;">NUCLEAR CARDIOLOGY</div> <input type="checkbox"/> MYOCARDIAL PERFUSION IMAGING (MPI) WITH VENTRICULAR FUNCTION <input type="checkbox"/> EXERCISE <input type="checkbox"/> PHARMACOLOGIC STRESS (PERSANTINE) <input type="checkbox"/> MYOCARDIAL VIABILITY STUDY (THALLIUM) <input type="checkbox"/> REST MUGA - VENTRICULAR FUNCTION (*Milton location only) <i>Note: Please consult your doctor regarding discontinuation of Beta Blockers (48hrs), Erectile Dysfunction medications (48hrs), and Calcium Blockers (24hrs) prior to cardiac stressing.</i>	<div style="background-color: #006633; color: white; text-align: center; padding: 2px;">X-RAY (No Appointment)</div> <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top; border: none;"> 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. </td> <td style="width:33%; vertical-align: top; border: none;"> 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: _____ </td> <td style="width:33%; vertical-align: top; border: none;"> UPPER EXTREMITIES R L <input type="checkbox"/> ELBOW <input type="checkbox"/> FOREARM <input type="checkbox"/> SHOULDER <input type="checkbox"/> HUMERUS <input type="checkbox"/> CLAVICLE <input type="checkbox"/> A.C. JOINTS <input type="checkbox"/> SCAPULA <input type="checkbox"/> WRIST <input type="checkbox"/> SCAPHOID <input type="checkbox"/> HAND & WRIST <input type="checkbox"/> HAND <input type="checkbox"/> FINGER: 1 2 3 4 5  </td> </tr> </table>	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.	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: _____	UPPER EXTREMITIES R L <input type="checkbox"/> ELBOW <input type="checkbox"/> FOREARM <input type="checkbox"/> SHOULDER <input type="checkbox"/> HUMERUS <input type="checkbox"/> CLAVICLE <input type="checkbox"/> A.C. JOINTS <input type="checkbox"/> SCAPULA <input type="checkbox"/> WRIST <input type="checkbox"/> SCAPHOID <input type="checkbox"/> HAND & WRIST <input type="checkbox"/> HAND <input type="checkbox"/> FINGER: 1 2 3 4 5 
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.	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: _____	UPPER EXTREMITIES R L <input type="checkbox"/> ELBOW <input type="checkbox"/> FOREARM <input type="checkbox"/> SHOULDER <input type="checkbox"/> HUMERUS <input type="checkbox"/> CLAVICLE <input type="checkbox"/> A.C. JOINTS <input type="checkbox"/> SCAPULA <input type="checkbox"/> WRIST <input type="checkbox"/> SCAPHOID <input type="checkbox"/> HAND & WRIST <input type="checkbox"/> HAND <input type="checkbox"/> FINGER: 1 2 3 4 5 		

 CARDIOLOGY **12-LEAD ELECTROCARDIOGRAM (REST ECG)** **ECHOCARDIOGRAM (COLOUR DOPPLER)** *Please select one of the following indications:* Chest pain suspicious of CAD Murmur Congestive heart failure Hypertension Palpitations / arrhythmias Syncope Other: _____ **EXERCISE STRESS TEST (TREADMILL)** **HOLTER MONITORING** A. 24 hrs B. 48 hrs C. 72 hrs D. 2 wks **24HR BP MONITOR (\$80.00 fee required)** || **CARDIAC CONSULTATION** **CONSULTATION REQUESTED** **URGENT, FIRST AVAILABLE CARDIOLOGIST** DR. ALI AKRAM DR. AMAN MUNDI DR. ABDULWAHAB ARRAGAGHI **CONSULT IF TEST RESULT IS POSITIVE / ABNORMAL** *Note: Please bring a list of all current prescription medications.* | **ULTRASOUND (By Appointment)** | | | | |---|--|--| | <input type="checkbox"/> OB U/S FOR DATING (< 16 weeks)
<input type="checkbox"/> OB U/S ROUTINE (18 – 20 weeks)
<input type="checkbox"/> GROWTH / BIOPHYSICAL PROFILE
<input type="checkbox"/> EFTS / IPS (between 11 – 13 weeks)
<input type="checkbox"/> ABDOMEN <input type="checkbox"/> LIMITED ABDOMEN
<input type="checkbox"/> THYROID <input type="checkbox"/> THYROID FNA
<input type="checkbox"/> SOFT TISSUE NECK | <input type="checkbox"/> KIDNEY
<input type="checkbox"/> FEMALE PELVIS
<input type="checkbox"/> MALE PELVIS
<input type="checkbox"/> HERNIA
<input type="checkbox"/> BREAST
<input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> BLADDER
<input type="checkbox"/> TRANSVAGINAL
<input type="checkbox"/> SCROTAL / TESTICULAR
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B | |---|--|--| |
| **GENERAL NUCLEAR MEDICINE** **BONE SCAN** WHOLE BODY OTHER SITE: _____ HEPATOBIILIARY SCAN RBC LIVER SCAN OTHER: _____ **BMD** 1st BASELINE BMD IN ONTARIO LOW RISK (2nd test - 36 months) LOW RISK (3rd test - 60 months) HIGH RISK (once every 12 months) | **MAMMOGRAPHY (By Appointment)** DIAGNOSTIC R L B OBSP (Ontario Breast Screening Program) |

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.

OBSTETRICAL / 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 MINERAL DENSITOMETRY (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.

PLEASE DO NOT WEAR ANY SCENTED PRODUCTS

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.

The appointment will take approximately 45 minutes.

MAMMOGRAM

Do not wear any deodorant, powder and perfume prior to appointment. Wear a separate blouse with skirt or slacks.



MISSISSAUGA

2300 Eglinton Ave. W., Suite G-02
Mississauga, ON L5M 2V8
Tel: 905-828-0653
Fax: 905-878-6575



MILTON

480 Bronte St. S., Suite 212
Milton, ON L9T 9A9
Tel: 905-878-8831
Fax: 905-878-6575