

PATIENT INFORMATION:

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

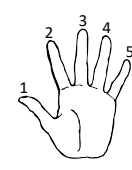
ADDRESS: _____

TELEPHONE #: _____ HEALTH CARD #: _____

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

*Note: Please see back for patient instructions and directions

 Check if applicable **STAT**

<div style="background-color: #e67e22; color: white; padding: 2px; text-align: center; font-weight: bold;">ULTRASOUND</div> <p>*By appointment</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> OB U/S for dating (<i>less than 16 weeks</i>)</td> <td><input type="checkbox"/> Thyroid and/or Neck</td> </tr> <tr> <td><input type="checkbox"/> OB U/S ROUTINE (<i>18 - 20 weeks</i>)</td> <td><input type="checkbox"/> Pelvis <input type="checkbox"/> Transvaginal</td> </tr> <tr> <td><input type="checkbox"/> OB U/S NON-ROUTINE</td> <td><input type="checkbox"/> Prostate <input type="checkbox"/> Transrectal</td> </tr> <tr> <td><input type="checkbox"/> Biophysical Profile (BPP)</td> <td><input type="checkbox"/> Renal</td> </tr> <tr> <td><input type="checkbox"/> IPS (<i>between 11 to 13 weeks</i>)</td> <td><input type="checkbox"/> Bladder</td> </tr> <tr> <td><input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta Only</td> <td><input type="checkbox"/> Scrotal / Testicular</td> </tr> <tr> <td><input type="checkbox"/> Inguinal Canal <input type="checkbox"/> R <input type="checkbox"/> L</td> <td><input type="checkbox"/> Soft Tissue: _____</td> </tr> <tr> <td><input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> OB U/S for dating (<i>less than 16 weeks</i>)	<input type="checkbox"/> Thyroid and/or Neck	<input type="checkbox"/> OB U/S ROUTINE (<i>18 - 20 weeks</i>)	<input type="checkbox"/> Pelvis <input type="checkbox"/> Transvaginal	<input type="checkbox"/> OB U/S NON-ROUTINE	<input type="checkbox"/> Prostate <input type="checkbox"/> Transrectal	<input type="checkbox"/> Biophysical Profile (BPP)	<input type="checkbox"/> Renal	<input type="checkbox"/> IPS (<i>between 11 to 13 weeks</i>)	<input type="checkbox"/> Bladder	<input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta Only	<input type="checkbox"/> Scrotal / Testicular	<input type="checkbox"/> Inguinal Canal <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Soft Tissue: _____	<input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Other: _____	<div style="background-color: #2e7d32; color: white; padding: 2px; text-align: center; font-weight: bold;">X-RAY</div> <p>*Queen St. location only</p> <table style="width:100%; border: none;"> <tr> <td style="vertical-align: top;"> HEAD & NECK <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Adenoids <input type="checkbox"/> Facial Bones <input type="checkbox"/> Eye for F.B. <input type="checkbox"/> Nose <input type="checkbox"/> Mandible <input type="checkbox"/> Orbits <input type="checkbox"/> TMJ - Temporomandibular Jt </td> <td style="vertical-align: top;"> 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. 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<input type="checkbox"/> I declare, to the best of my knowledge, that I am NOT presently pregnant. _____																													

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

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 FINISHED 1 hour prior to appointment.

Do not empty bladder before examination.

PROSTATE (TRANSRECTAL)

Fleet enema 2 hours prior to the examination (kit may be purchased at your pharmacy). Drink 20 oz of water FINISHED 1 hour prior to appointment.

OTHER

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

CARDIOLOGY

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.

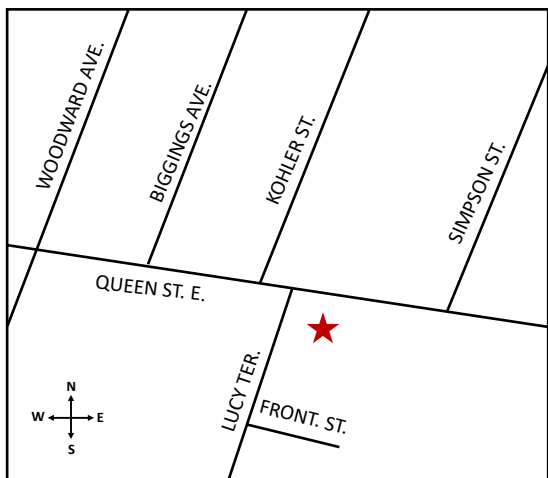
BONE MINERAL DENSITY

Do not take calcium/vitamin supplements 24 hours prior to exam.

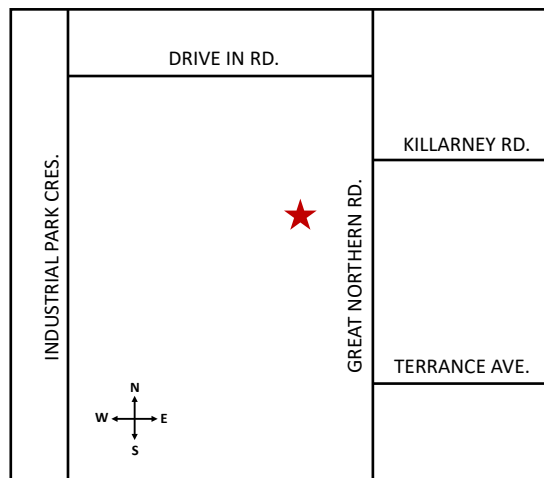
If you have had a nuclear medicine dye injection or a barium study within 2 weeks, please reschedule your BMD test.

Patients are asked to wear clothing without zippers or metal attachments.

PLEASE DO NOT WEAR ANY SCENTED PRODUCTS



955 Queen Street East, Unit 50
 Sault Ste. Marie, ON P6A 2C3
 Tel: 705-759-1144 | Fax: 705-759-5978



683 Great Northern Road, Unit 1
 Sault Ste. Marie, ON P6A 5A1
 Tel: 705-251-3467 | Fax: 705-251-3468
 *ULTRASOUND ONLY