

**PATIENT INFORMATION:**

PATIENT'S NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_  F  M  
 ADDRESS: \_\_\_\_\_  
 TELEPHONE #: \_\_\_\_\_ HEALTH CARD #: \_\_\_\_\_  
 APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ LMP: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
 Check if applicable  **STAT**

ULTRASOUND	MSK ULTRASOUND
<input type="checkbox"/> OB U/S ROUTINE (18 – 20 weeks) <input type="checkbox"/> OB U/S for dating (less than 16 weeks) <input type="checkbox"/> OB U/S NON-ROUTINE <input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta Only <input type="checkbox"/> Inguinal Canal <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Pelvis <input type="checkbox"/> Transvaginal <input type="checkbox"/> Transrectal / Prostate <input type="checkbox"/> Biopsy <input type="checkbox"/> Renal <input type="checkbox"/> Bladder <input type="checkbox"/> Scrotal / Testicular <input type="checkbox"/> Thyroid and/or Neck <input type="checkbox"/> Soft Tissue: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Rotator Cuff <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Achilles <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Other: _____
	BONE MINERAL DENSITY
	<input type="checkbox"/> 1 <sup>st</sup> Baseline BMD in Ontario <input type="checkbox"/> Low Risk (2 <sup>nd</sup> test - 36 months) <input type="checkbox"/> Low Risk (3 <sup>rd</sup> test - 60 months) <input type="checkbox"/> High Risk (once every 12 months)

\*Note: Please see back for patient instructions and directions. Patients who arrive late may have to reschedule their appointment to another date. If late arriving, patients who can be accommodated on the same day must be prepared to wait until the scanning room becomes available.

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](http://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.**

**OBSTETRICAL / PELVIS**

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

**Do not empty bladder before examination.**

**PROSTATE (TRANSRECTAL)**

Fleet enema 2 hours before the examination (kit may be purchased at your pharmacy). Drink 34 oz or 1 litre of water FINISHED 1 hour prior to appointment.

**OTHER**

No preparation required for the following exams: Thyroid, Breast, Scrotum and MSK.

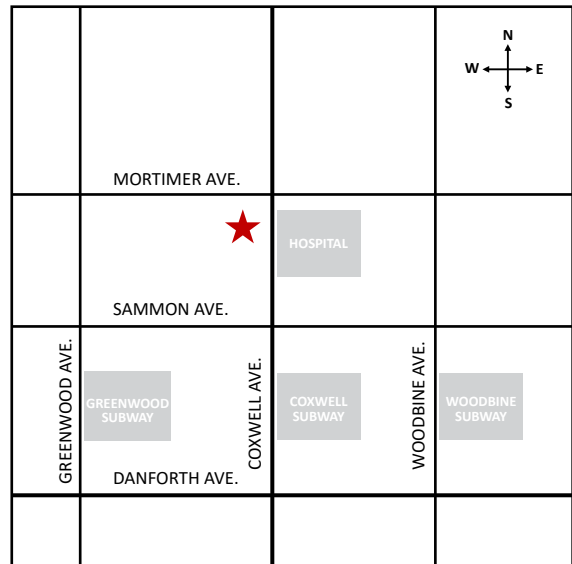
**BONE MINERAL DENSITY**

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**



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