

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**

<p>NUCLEAR CARDIOLOGY</p> <p><input type="checkbox"/> MYOCARDIAL PERFUSION IMAGING (MPI) with ventricular function <input type="checkbox"/> Exercise <input type="checkbox"/> Pharmacologic Stress (Persantine)</p> <p><input type="checkbox"/> MYOCARDIAL WALL MOTION (MUGA) with ejection fraction</p> <p><input type="checkbox"/> MYOCARDIAL VIABILITY STUDY (THALLIUM)</p> <p>Note: Please consult your doctor regarding discontinuation of Beta Blockers (48hrs), Erectile Dysfunction medications (48hrs), and Calcium Blockers (24hrs) prior to cardiac stressing.</p>	<p>GENERAL NUCLEAR MEDICINE</p> <p>BONE SCAN <input type="checkbox"/> Whole Body <input type="checkbox"/> Specific Site: _____</p> <p>ENDOCRINE <input type="checkbox"/> Renal Flow & Scan <input type="checkbox"/> Renal Flow with Captopril <input type="checkbox"/> Renal Flow with Lasix <input type="checkbox"/> Hepatobiliary Scan with EF <input type="checkbox"/> Parathyroid Scan</p> <p>GASTROINTESTINAL <input type="checkbox"/> Gastric Emptying Scan <input type="checkbox"/> Biliary Scan <input type="checkbox"/> Liver / Spleen Scan <input type="checkbox"/> G.I. Bleeding Scan <input type="checkbox"/> Hemangioma Scan <input type="checkbox"/> Meckel's Scan <input type="checkbox"/> Salivary Scan <input type="checkbox"/> Other: _____</p>
<p>CARDIOLOGY</p> <p><input type="checkbox"/> 12-LEAD ELECTROCARDIOGRAM (ECG)</p> <p><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"/> Congestive heart failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Palpitations / arrhythmias <input type="checkbox"/> Syncope <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> EXERCISE STRESS TEST (GXT)</p> <p><input type="checkbox"/> HOLTER MONITORING <input type="checkbox"/> 24 hrs <input type="checkbox"/> 48 hrs <input type="checkbox"/> 72 hrs <input type="checkbox"/> 1 wk <input type="checkbox"/> 2 wks</p> <p><input type="checkbox"/> 24HR BP MONITOR (\$80.00 fee required)</p>	<p>ULTRASOUND</p> <p><input type="checkbox"/> OB U/S for dating (<i>less than 6 weeks</i>) <input type="checkbox"/> OB U/S ROUTINE (<i>18 – 20 weeks</i>) <input type="checkbox"/> OB U/S NON-ROUTINE <input type="checkbox"/> IPS (<i>between 11 to 13 weeks</i>) <input type="checkbox"/> Full Abdomen (<i>includes limited pelvic screen (no pelvic prep required)</i>) <input type="checkbox"/> Upper Abdomen Only (<i>no pelvic screen</i>) <input type="checkbox"/> Aorta Only <input type="checkbox"/> Pelvic <input type="checkbox"/> Proceed to transvaginal, if appropriate <input type="checkbox"/> Renal <input type="checkbox"/> Bladder <input type="checkbox"/> Scrotal / Testicular <input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Soft Tissue Neck / Abdominal Wall <input type="checkbox"/> Thyroid <input type="checkbox"/> Other: _____</p> <p>MSK R L <input type="checkbox"/> <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> <input type="checkbox"/> Elbow <input type="checkbox"/> <input type="checkbox"/> Wrist <input type="checkbox"/> <input type="checkbox"/> Knee <input type="checkbox"/> <input type="checkbox"/> Popliteal Fossa <input type="checkbox"/> <input type="checkbox"/> Ankle <input type="checkbox"/> <input type="checkbox"/> Achille</p>
<p>CARDIOLOGY CONSULTATION</p> <p><input type="checkbox"/> CONSULTATION REQUESTED <input type="checkbox"/> Urgent, first available cardiologist <input type="checkbox"/> Dr. Gerald Wisenberg <input type="checkbox"/> Dr. _____</p> <p><input type="checkbox"/> CONSULT IF TEST RESULT IS POSITIVE / ABNORMAL</p>	<p>VASCULAR DOPPLER</p> <p><input type="checkbox"/> Carotid</p> <p><input type="checkbox"/> Venous - Lower Extremity (DVT) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Venous - Upper Extremity (DVT) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Arterial - Lower Extremity (with ABI) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Arterial - Upper Extremity <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B</p>

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, STRESS TESTING & CONSULTATIONS

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 / PELVIC

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.

START AT: _____ FINISH BY: _____

Do not empty bladder before examination.

OBSTETRICS / PELVIC

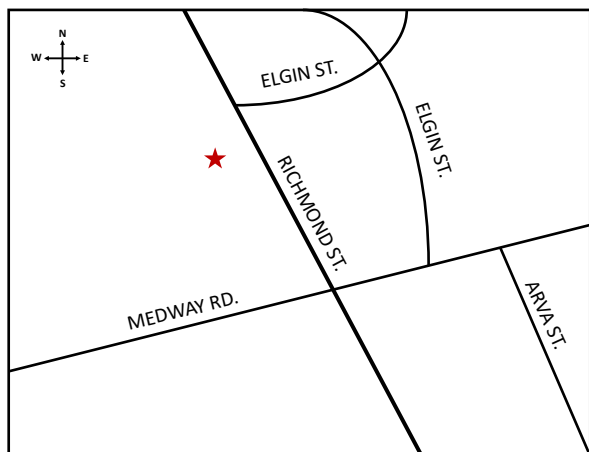
Drink 34 oz or 1 litre of water 1 hour prior to appointment.

START AT: _____ FINISH BY: _____

Do not empty bladder before examination.

OTHER

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



GENERAL NUCLEAR MEDICINE

BILIARY SCAN

Nothing to eat or drink 4 hours prior to appointment.

RENAL SCAN

Drink 2 cups of water 1 hour prior to appointment.
Bring all blood pressure medications.

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: 2 hours

GASTRIC EMPYTING SCAN

You will be given a radioactive meal of scrambled egg whites on toast. You will then be imaged for one minute and asked to return in one hour intervals for one minute images until stomach contents fall below a certain level.

No eating or drinking for 6 - 8 hours prior to appointment. Medication, prokinetics, opiates and antispasmodics need to be discontinued for 2 days prior to testing. Please inform us of any dairy allergies.

21589 Richmond Street

Arva, ON N0M 1C0

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*Clinic is located south of Arva Appliances on Richmond Street