

**\*Call 705-673-2565 to book an appointment**

www.myhealthcentre.ca

**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

WSIB

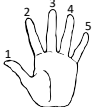
Check if applicable  **URGENT**

**ULTRASOUND (By Appointment)**

<input type="checkbox"/> Follicular Studies	<b>MSK</b>
<input type="checkbox"/> OB U/S for dating ( <i>less than 16 weeks</i> )	<b>R L</b>
<input type="checkbox"/> OB U/S ROUTINE ( <i>18 – 20 weeks</i> )	<input type="checkbox"/> Rotator Cuff
<input type="checkbox"/> OB U/S NON-ROUTINE	<input type="checkbox"/> Elbow
<input type="checkbox"/> Biophysical Profile	<input type="checkbox"/> Wrist
<input type="checkbox"/> IPS ( <i>between 11 to 13 weeks</i> )	<input type="checkbox"/> Hip
<input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta Only	<input type="checkbox"/> Knee & Popfossa
<input type="checkbox"/> Inguinal Canal <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Ankle
<input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Achille
<input type="checkbox"/> Pelvis <input type="checkbox"/> Transvaginal <input type="checkbox"/> Scrotal / Testicular	
<input type="checkbox"/> Transrectal / Prostate	<input type="checkbox"/> Soft Tissue: _____
<input type="checkbox"/> Bladder <input type="checkbox"/> Renal	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Thyroid	<input type="checkbox"/> FNA / Biopsy
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Salivary Gland

**X-RAY (No appointment required)**

<b>HEAD &amp; NECK</b>	<b>SPINE &amp; PELVIS</b>	<b>UPPER EXTREMITIES</b>
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Cervical Spine	<b>R L</b>
<input type="checkbox"/> Skull	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Elbow
<input type="checkbox"/> Sinuses	<input type="checkbox"/> Lumbar (L/S) Spine	<input type="checkbox"/> Forearm
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Sacrum / Coccyx	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Nose	<input type="checkbox"/> S.I. Joints	<input type="checkbox"/> Humerus
<input type="checkbox"/> Mandible	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Clavicle
<input type="checkbox"/> Orbits	<input type="checkbox"/> Scoliosis Series	<input type="checkbox"/> A.C. Joints
<input type="checkbox"/> TMJ - Temporomandibular Jt		<input type="checkbox"/> Scapula
<b>CHEST</b>	<b>LOWER EXTREMITIES</b>	<input type="checkbox"/> Wrist
<input type="checkbox"/> Chest PA & LAT	<b>R L</b>	<input type="checkbox"/> Scaphoid
<input type="checkbox"/> Ribs <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hip	<input type="checkbox"/> Hand
<input type="checkbox"/> Sternoclavicular Joints	<input type="checkbox"/> Femur	<input type="checkbox"/> Finger: 1 2 3 4 5
<input type="checkbox"/> Sternum	<input type="checkbox"/> Knee	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Tib. & Fib.	<input type="checkbox"/> LEG LENGTHS
	<input type="checkbox"/> Ankle	<input type="checkbox"/> OTHER X-RAY: _____
<b>ABDOMINAL</b>	<input type="checkbox"/> Foot	
<input type="checkbox"/> Single / KUB	<input type="checkbox"/> Heel	
<input type="checkbox"/> Acute ( <i>includes PA chest</i> )	<input type="checkbox"/> Toe: 1 2 3 4 5	
<b>GASTRICS (By Appointment)</b>		
<input type="checkbox"/> Upper GI <input type="checkbox"/> Small Bowel <input type="checkbox"/> Upper GI & Small Bowel <input type="checkbox"/> Barium Swallow		



**VASCULAR DOPPLER (By Appointment)**

<input type="checkbox"/> Carotids	
<input type="checkbox"/> Venous - Lower Extremity (DVT ONLY)	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Venous - Upper Extremity	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Arterial - Lower Extremity with ABI	<input type="checkbox"/> B
<input type="checkbox"/> Arterial - Upper Extremity	<input type="checkbox"/> B
<input type="checkbox"/> Renal Artery	

**BONE MINERAL DENSITY (By Appointment)**

Baseline Study

Follow Up

**NUCLEAR CARDIOLOGY (By Appointment)**

**MYOCARDIAL WALL MOTION (MUGA)**  
with ejection fraction

**MYOCARDIAL PERFUSION IMAGING (MPI)**  
with ventricular function

Exercise     Pharmacologic Stress (Persantine)

*Indication for ordering MPI procedures:*

Abnormal Exercise / Rest ECG     Post M.I.

Atypical (variant) angina / SOBOE     Rule out CAD (CRF with symptoms)

Typical Angina     Other: \_\_\_\_\_

**\*Physician Note:** Please advise patient to stop any Beta Blockers (48hrs) and Calcium Blockers (24hrs) prior to cardiac testing.

**GENERAL NUCLEAR MEDICINE (By Appointment)**

<b>BONE SCAN</b>	<b>GASTROINTESTINAL</b>
<input type="checkbox"/> Whole Body	<input type="checkbox"/> Gastric Emptying Scan
<input type="checkbox"/> Specific Site: _____	<input type="checkbox"/> Biliary Scan <input type="checkbox"/> with CCK
<b>ENDOCRINE</b>	<input type="checkbox"/> Liver / Spleen Scan
<input type="checkbox"/> Thyroid <input type="checkbox"/> Parathyroid	<input type="checkbox"/> RBC Liver Scan
<i>Indication for ordering thyroid scan:</i>	<input type="checkbox"/> Salivary Scan
<input type="checkbox"/> Hypertthyroidism	<input type="checkbox"/> Meckel's Scan
<input type="checkbox"/> Other: _____	

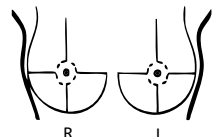
**MAMMOGRAPHY (By Appointment)**

Mammogram

R     L     B     Implants

Ultrasound Breast

OBSP (Ontario Breast Screening Program)  
*50-74 years old. No requisition required.*



Clinical Information: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Print Name    \_\_\_\_\_ Signature    Fax #: \_\_\_\_\_

Copy To: \_\_\_\_\_ Print Name    Fax #: \_\_\_\_\_

#### HOURS OF OPERATION

**65 Larch St.:** Mon.-Thurs. 07:30-20:00, Fri. 07:30-17:00, Sat. 08:00-16:00

**1122 Lasalle Blvd.:** Mon.-Thurs. 08:00-20:00, Fri. 08:00-17:30, Sat. 08:00-16:00

**2009 Long Lake Rd.:** Mon.-Fri. 08:00-17:00

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### 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)

### 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. START AT: \_\_\_\_\_ FINISH BY: \_\_\_\_\_

**Do not empty bladder before examination.**

#### OBSTETRICAL / PELVIS

Drink 34 oz or 1 litre of water. START AT: \_\_\_\_\_ FINISH BY: \_\_\_\_\_

**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. START AT: \_\_\_\_\_ FINISH BY: \_\_\_\_\_

### 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

### MAMMOGRAM

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

### GASTRICS

#### STOMACH, UGI, BARIUM SWALLOW, SMALL BOWEL

Nothing to eat or drink after midnight, which includes chewing gum, candies and smoking.

For Small Bowel, please allow 1 to 2 hours for appointment.

### 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.

**PLEASE DO NOT WEAR ANY SCENTED PRODUCTS**

### THYROID UPTAKE AND SCAN

Thyroid medications might affect the results of this test. Please inform staff at the time of booking if you are taking any thyroid medications.

You will be given an Iodine capsule and instructed to return in 24 hours for an injection and imaging.

Total test time: Day 1 - 15 minutes, Day 2 - 45 minutes