

- Brantford
- London Southdale

- Delhi
- London Wharncliffe

- London Arva
- Sarnia

- London Fanshawe
- Simcoe

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Check if Applicable: **URGENT**

Full Name (Birth): _____

Preferred Full Name (If Different from Birth): _____

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Cell Phone: _____ Alt. Phone: _____

Date of Birth: _____ Health Card #: _____ Version: _____

Gender (Birth): _____ Preferred Gender (If Different from Birth): _____

Height (cm): _____ Weight (kg): _____

Reason for Referral: _____

CARDIOLOGY CONSULTATION

First Available Consult if Test Result is Positive/Abnormal

Dr. _____

Please Attach: Medications, Previous Tests, Family & Social History

CARDIOLOGY

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> 12-Lead Electrocardiogram (Rest ECG) <input type="checkbox"/> Exercise Stress Test (GXT) <input type="checkbox"/> Holter Monitoring <ul style="list-style-type: none"> <input type="radio"/> 24 hrs <input type="radio"/> 48 hrs <input type="radio"/> 72 hrs <input type="radio"/> Other: _____ <input type="checkbox"/> 24hr BP Monitor (Not insured by OHIP) <input type="checkbox"/> Pulmonary Function Testing - Simcoe <ul style="list-style-type: none"> <input type="radio"/> Pre & Post Spirometry <input type="radio"/> Full Pulmonary Function Test <input type="radio"/> Include Respirology Consult | <ul style="list-style-type: none"> <input type="checkbox"/> Echocardiogram (Colour Doppler) <input type="checkbox"/> Contrast Echocardiogram <ul style="list-style-type: none"> <input type="radio"/> Chest pain suspicious of CAD <input type="radio"/> Congestive heart failure <input type="radio"/> Hypertension <input type="radio"/> Murmur <input type="radio"/> Palpitations/arrhythmias <input type="radio"/> Syncope <input type="radio"/> Other: _____ |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

NUCLEAR CARDIOLOGY

- | | |
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| <p>MYOCARDIAL PERFUSION</p> <ul style="list-style-type: none"> <input type="checkbox"/> Exercise <input type="checkbox"/> Persantine <input type="checkbox"/> Dobutamine | <p>VENTRICULAR FUNCTION</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rest MUGA - Simcoe |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|

X-RAY (WALK-IN SERVICE)

- | | | |
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| <p>ABDOMINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Single/KUB <input type="checkbox"/> Acute (Incl. PA chest) <p>CHEST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest PA & LAT <input type="checkbox"/> Screening Chest X-ray (Not insured by OHIP) <input type="checkbox"/> Ribs <input type="radio"/> OR <input type="radio"/> L <input type="checkbox"/> Sternum <input type="checkbox"/> Chest Visa <p>HEAD & NECK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses (Not insured by OHIP) <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nose <input type="checkbox"/> Mandible <input type="checkbox"/> Orbits <input type="checkbox"/> T.M. Joints <input type="checkbox"/> Adenoids | <p>LOWER EXTREMITIES</p> <p>R L</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hip <input type="checkbox"/> Femur <input type="checkbox"/> Arthritic Knee (Incl. contra-lateral) <input type="checkbox"/> Knee <input type="checkbox"/> Tib. & Fib. <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Calcaneus <input type="checkbox"/> Toe: 1 2 3 4 5 <p>SPINE & PELVIS</p> <ul style="list-style-type: none"> <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 <input type="checkbox"/> Scoliosis Series | <p>UPPER EXTREMITIES</p> <p>R L</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shoulder <input type="checkbox"/> Clavicle <input type="checkbox"/> Sternoclavicular joints <input type="checkbox"/> A.C. Joint <input type="checkbox"/> Scapula <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Scaphoid <input type="checkbox"/> Hand <input type="checkbox"/> Finger: 1 2 3 4 5 <p>OTHER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skeletal Survey <input type="checkbox"/> Bone Age <input type="checkbox"/> Indicate: _____ |
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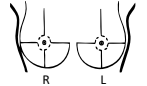


ULTRASOUND

- GENERAL ULTRASOUND**
- Abdomen + Pelvis (Incl. reproductive organs)
 - Abdomen (Incl. limited bladder + lower quadrants, no reproductive organs)
 - Kidneys*
 - Bladder
 - Hernia (specify site): _____
 - Other: _____
- *Baseline abdominal ultrasound may be performed
- MUSCULOSKELETAL**
- R L**
- Shoulder
 - Elbow
 - Wrist
 - Hip
 - Hamstring
 - Knee
 - Ankle/Achilles Tendon/Plantar Fascia (circle one above)
 - Other: _____
- SMALL PARTS**
- Salivary Glands
 - Thyroid
 - Chest
 - Groin R L
 - Inguinal Canal R L
 - Testes/Scrotum
 - Soft Tissue/Lump (specify site): _____
- PELVIS**
- Female Pelvis (Incl. Transvaginal)
 - Male Pelvis (Excl. Transrectal)
- OBSTETRICAL**
- EDC (Required):** _____
- Dating (< 16 weeks)
 - Prenatal Screening (IPS/eFTS 11-14 weeks)
 - Anatomy (18-20 weeks)
 - Dual Scan Series (NT scan 11-14 weeks + Anatomical 18-20 weeks)
 - Fetal Growth (30+ weeks)
 - BPP UA Doppler MCA Doppler
 - Biophysical Profile (BPP)
 - Follicular Study
- NEONATAL**
- Hip (6 weeks-6 months)
 - Pyloric Stenosis (Birth-6 months)
 - Spine (Birth-4 months)
- VASCULAR**
- R L**
- Venous - Lower Extremity (DVT)
 - Venous - Upper Extremity (DVT)
 - Venous - Lower Extremity (Reflux)
 - Arterial - Lower Extremity (ABI)
 - Arterial - Upper Extremity
 - Carotid
 - Renal Arteries
 - Portal Venous Doppler
 - Aorta: _____
 - OTHER:** _____

MAMMOGRAPHY & WOMEN'S IMAGING

- Targeted Breast Ultrasound* (indicate quadrant on diagram) R L
 - Mammogram R L Implants
 - Mammogram & Bone Mineral Density R L Implants | Baseline Follow Up
- *Breast ultrasound is not used for screening purposes. Mammogram/OBSP is recommended.



BONE MINERAL DENSITY

- Baseline Follow Up

NUCLEAR MEDICINE (SIMCOE)

- | | |
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| <p>BONE SCAN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Total Body <input type="checkbox"/> Specific Site: _____ <p>ENDOCRINE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thyroid Uptake & Scan <input type="checkbox"/> Parathyroid <p>GALLIUM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Total Body <input type="checkbox"/> Specific Site: _____ <p>GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hepatobiliary Scan (HIDA) <input type="checkbox"/> Solid Gastric Emptying Scan <input type="checkbox"/> GI Bleeding Scan | <p>RENAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Renal Scan with Differential Function <input type="checkbox"/> Lasix Renal <input type="checkbox"/> Captopril Renal <p>MISCELLANEOUS</p> <ul style="list-style-type: none"> <input type="checkbox"/> V/Q Lung Scan <input type="checkbox"/> Salivary Scan <input type="checkbox"/> Lacrimal Scan <input type="checkbox"/> Sentinel Node <p>PET/CT – Mississauga</p> <ul style="list-style-type: none"> <input type="checkbox"/> Visit WELLdiagnostics.ca/Refer for PET/CT requisition |
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REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)

Referring Provider: _____ (Print Name) _____ (Signature)

Billing Provider #: _____ CPSO #: _____

Tel #: _____ Fax #: _____

Date: _____ Copy To: _____

Report Delivery Preference: Fax HRM Other: _____

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- **We will send your diagnostic report to your referring HP (healthcare provider), who will follow-up with you.** We can send it to additional HPs upon your request.

BRANTFORD	DELHI	LONDON ARVA
<p>Brantford Medical Centre 40 Shellington Place, Suite 201 Brantford, ON N3S 0C5</p> <p>T: 519-805-3560 F: 519-805-3561 E: brantford@welldiagnostics.ca</p> <p>SERVICES: Blood Pressure Monitoring, Cardiology Consultation, Contrast Echo, Echocardiogram, Electrocardiogram, Exercise Stress Test, Holter Monitoring</p>	<p>105 Main Street Delhi, ON N4B 2L8 Delhi Community Health Centre on Main Street, north of King Street</p> <p>T: 519-428-1243 F: 519-428-2445 E: delhi@welldiagnostics.ca</p> <p>SERVICES: Prenatal Screening, Ultrasound, Vascular Ultrasound</p>	<p>21589 Richmond Street Arva, ON N0M 1C0 Richmond Street, north of the London Masonville Mall</p> <p>T: 519-672-0070 F: 519-850-0144 E: london_arva@welldiagnostics.ca</p> <p>SERVICES: Blood Pressure Monitoring, Cardiology Consultation, Contrast Echo, Echocardiogram, Electrocardiogram, Exercise Stress Test, Holter Monitoring, Prenatal Screening, Ultrasound</p>
LONDON FANSHAWE	LONDON SOUTHDALE	LONDON WHARNCLIFFE (CARDIOLOGY)
<p>1055 Fanshawe Park Road West, Suite 301 London, ON N6G 5B4 North London Medical Centre on Fanshawe just east of Hyde Park Road</p> <p>T: 519-439-5555 F: 519-266-2206 E: london_fanshawe@welldiagnostics.ca</p> <p>SERVICES: Bone Mineral Density, Mammography & OBSP, Nuclear Cardiology, Pain Injection, Prenatal Screening, Ultrasound, Vascular Ultrasound, X-ray (Walk-in Service)</p>	<p>510 Southdale Road East, Suite 103 London, ON N6E 0B2 Nixon Medical Centre at the corner of Nixon and Southdale Road</p> <p>T: 226-663-2933 F: 226-663-4561 E: london_southdale@welldiagnostics.ca</p> <p>SERVICES: Prenatal Screening, Ultrasound, Vascular Ultrasound, X-ray (Walk-in Service)</p>	<p>279 Wharncliffe Road North, Suite 210 London, ON N6H 2C2 Wharncliffe Health Centre, north of Oxford Street</p> <p>T: 519-858-7476 F: 519-266-6739 E: london_wharncliffe_cardiology@welldiagnostics.ca</p> <p>SERVICES: Blood Pressure Monitoring, Cardiology Consultation, Contrast Echo, Echocardiogram, Electrocardiogram, Exercise Stress Test, Holter Monitoring</p>
LONDON WHARNCLIFFE (RADIOLOGY)	SARNIA	SIMCOE
<p>279 Wharncliffe Road North, Suite 111 London, ON N6H 2C2 Wharncliffe Health Centre, north of Oxford Street</p> <p>T: 519-661-0275 F: 519-661-0616 E: london_wharncliffe_radiology@welldiagnostics.ca</p> <p>SERVICES: Bone Mineral Density, Mammography & OBSP, Prenatal Screening, Ultrasound, Vascular Ultrasound, X-ray (Walk-in Service), Immigration X-ray</p>	<p>481 London Road, Suite B-101 Sarnia, ON N7T 4X3 Bluewater Medical Clinic beside the hospital</p> <p>T: 519-336-8110 F: 1-800-507-3880 E: sarnia@welldiagnostics.ca</p> <p>SERVICES: Blood Pressure Monitoring, Bone Mineral Density, Mammography & OBSP, Cardiology Consultation, Contrast Echo, Echocardiogram, Electrocardiogram, Exercise Stress Test, Holter Monitoring, Nuclear Cardiology, Prenatal Screening, Ultrasound, Vascular Ultrasound, X-ray (Walk-in Service)</p>	<p>216 West Street, Suite 304 Simcoe, ON N3Y 1S8 West Street Health Centre at the corner of Queen and West Street</p> <p>T: 519-428-1243 F: 519-428-2445 E: simcoe@welldiagnostics.ca</p> <p>SERVICES: Blood Pressure Monitoring, Bone Mineral Density, Cardiology Consultation, Contrast Echo, Echocardiogram, Electrocardiogram, Exercise Stress Test, Holter Monitoring, Nuclear Cardiology, Nuclear Medicine, Prenatal Screening, Pulmonary Function Test, Respiratory Consultation, Ultrasound, Vascular Ultrasound, X-ray (Walk-in Service)</p>



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