

Name		D.O.B.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Health No. & V.C.	<input type="checkbox"/> STAT <input type="checkbox"/> VERBAL RR IMAGING (Paid Parking) <input type="checkbox"/> 234 Eglinton Ave E, Unit 207 Toronto, ON M4P 1K5 Ph: 416-485-9471 Fax: 416-485-9309 CLINIC HOURS Mon-Friday: 7:00 AM to 6 PM Saturday: 8:00 AM to 3 PM • X-RAY • ULTRASOUND
Address:		Tel:			
VASCULAR ULTRASOUND (BY APPOINTMENT ONLY)		BREAST IMAGING (BY APPOINTMENT ONLY)			NORTH YORK <input type="checkbox"/> 491 Lawrence Ave W, LL2 North York, ON, M5M 1C7 Ph: 416-781-9940 Fax: 416-781-7175 CLINIC HOURS Mon-Friday: 7:00 AM to 6 PM Saturday: 8:00 AM to 3 PM • X-RAY • ULTRASOUND • BMD • MAMMOGRAPHY
<input type="checkbox"/> Carotid <input type="checkbox"/> Renal <input type="checkbox"/> Arterial Extremity <input type="checkbox"/> ARM <input type="checkbox"/> LEG <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> B <input type="checkbox"/> Venous Extremity <input type="checkbox"/> ARM <input type="checkbox"/> LEG <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> B		MAMMOGRAPHY <input type="checkbox"/> ⊕ Left <input type="checkbox"/> ⊕ Right <input type="checkbox"/> Bilateral By signing this requisition you are authorizing your patient to be referred on your behalf to William Osler Health System for additional breast assessment as needed BREAST ULTRASOUND <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral			
ULTRASOUND EXAMINATION (BY APPOINTMENT ONLY)		BONE DENSITY (NO APPOINTMENT REQUIRED)			HUMBER DIAGNOSTICS <input type="checkbox"/> 1017 Wilson Ave, Suite 100 North York, ON M3K 1Z1 Ph: 416-631-7581 Fax: 416-631-9759 CLINIC HOURS Mon-Thurs: 8:00 AM to 6 PM Friday: 8:00 AM to 5 PM Saturday: 8:00 AM to 3 PM • X-RAY • ULTRASOUND • BMD • CARDIOLOGY
GENERAL <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen + Fibrosis <input type="checkbox"/> Abdomen + NAFLD <input type="checkbox"/> Abdomen + ALD (Alcoholic Liver Disease) <input type="checkbox"/> Pelvic <input type="checkbox"/> Transvaginal <input type="checkbox"/> Renal + Bladder <input type="checkbox"/> PVR-Post Void Residual <input type="checkbox"/> Abdominal Wall <input type="checkbox"/> Prostate-Transrectal <input type="checkbox"/> Testicular / Scrotum <input type="checkbox"/> Transvaginal <input type="checkbox"/> Aorta <input type="checkbox"/> Inguinal Canal/Hernia <input type="checkbox"/> Thyroid <input type="checkbox"/> Neck Mass <input type="checkbox"/> Salivary Glands LIVER (Non-OHIP) <input type="checkbox"/> Fibrosis <input type="checkbox"/> NAFLD <input type="checkbox"/> ALD (Alcoholic Liver Disease) ULTRASOUND GUIDED PROCEDURES (WILSON LOCATION) <input type="checkbox"/> <input type="checkbox"/> R Thyroid FNA <input type="checkbox"/> <input type="checkbox"/> R Lymph Node FNA <input type="checkbox"/> <input type="checkbox"/> R Bursa <input type="checkbox"/> <input type="checkbox"/> R Joints <input type="checkbox"/> <input type="checkbox"/> R Tendons <input type="checkbox"/> <input type="checkbox"/> R Foot OBSTETRICAL <input type="checkbox"/> OB Dating (<16wks) <input type="checkbox"/> IPS (NT) (11-13 wks, 6 days) <input type="checkbox"/> OB Routine Anatomy Scan (18-20wks) <input type="checkbox"/> Biophysical Profile (> 30wks) <input type="checkbox"/> OB High Risk <input type="checkbox"/> OB Follow Up <input type="checkbox"/> HYSTEROSONOGRAM MUSCULOSKELETAL <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Hip <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Hamstring <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Knee <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Achilles Tendon <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Ankle <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Foot <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Shoulder <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Elbow <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Wrist <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Other Muscle Area <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Other Soft Tissue		CARDIOLOGY <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Resting ECG <input type="checkbox"/> Stress Echocardiogram <input type="checkbox"/> Stress ECG/GXT <input type="checkbox"/> Holter Monitor 48hrs 72hrs 1wk 2wks CONSULTATIONS <input type="checkbox"/> Cardiology <input type="checkbox"/> Internal Medicine			
		X-RAY (NO APPOINTMENT REQUIRED)			ALBION <input type="checkbox"/> 1525 Albion Rd, LL4 Etobicoke, ON, M9V 5G5 Ph: 416-741-5661 Fax: 416-741-6417 CLINIC HOURS Mon-Friday: 7:00 AM to 6 PM Saturday: 8:00 AM to 3 PM • X-RAY • ULTRASOUND • BMD • MAMMOGRAPHY • VASCULAR ULTRASOUND
		ABDOMEN <input type="checkbox"/> Single view (KUB) <input type="checkbox"/> Acute (includes Chest PA) HEAD & NECK <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Soft Tissue of Neck <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Facial Bones <input type="checkbox"/> Mandible <input type="checkbox"/> T.M. Joints <input type="checkbox"/> Orbits CHEST <input type="checkbox"/> Chest (PA & LAT) <input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B (Includes Chest PA) <input type="checkbox"/> Sternum <input type="checkbox"/> S.C. Joints <input type="checkbox"/> Immigration Chest (PA) UPPER EXTREMITIES <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Shoulder <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Clavicle <input type="checkbox"/> <input type="checkbox"/> B A.C. Joints <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Scapula <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Humerus <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Elbow <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Forearm			
		<input type="checkbox"/> <input type="checkbox"/> R Wrist <input type="checkbox"/> <input type="checkbox"/> R Scaphoid <input type="checkbox"/> <input type="checkbox"/> R Hand <input type="checkbox"/> <input type="checkbox"/> R Finger - N° 1 2 3 4 5 SKELETAL SURVEY <input type="checkbox"/> Metastatic Series <input type="checkbox"/> Arthritic Series <input type="checkbox"/> Metabolic Series <input type="checkbox"/> Bone Age LOWER EXTREMITIES <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Hip <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Femur <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Knee <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Tib & Fib <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Ankle <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Foot <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Calcaneus <input type="checkbox"/> <input type="checkbox"/> R <input type="checkbox"/> B Toes - N° 1 2 3 4 5 SPINE & PELVIS <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbo-Sacral Spine <input type="checkbox"/> Sacrum & Coccyx <input type="checkbox"/> S.I. Joints <input type="checkbox"/> AP Pelvis <input type="checkbox"/> Pelvis & Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Scoliosis Series			
I DECLARE THAT I AM NOT PRESENTLY PREGNANT _____ <div style="text-align: right;">SIGNATURE</div>					HUMBER <input type="checkbox"/> 100 Humber College Blvd, Suite 106A Rexdale, ON, M9V 5G4 Ph: 416-745-4550 Fax: 416-745-4048 CLINIC HOURS Mon-Friday: 8:00 AM to 6 PM Saturday: 8:00 AM to 3 PM Sunday: 9:00 AM to 3 PM • X-RAY • ULTRASOUND
CLINICAL INFORMATION REQUIRED: MD: _____ CC: _____ <input type="checkbox"/> X-RAY <input type="checkbox"/> ULTRASOUND					
PLEASE BRING YOUR HEALTH CARD & THIS REQUEST FORM Last Patient Registration Half an Hour Before Closing This requisition form can be taken to any licensed facility providing healthcare services including hospitals and I.H.F.s, such as those on the I.H.F. Program website					REXDALE <input type="checkbox"/> 123 Rexdale Blvd, Unit 6 Etobicoke, ON M9W 1P1 Ph: 416-746-3828 Fax: 416-746-6397 CLINIC HOURS Mon-Friday: 8:00 AM to 6 PM Saturday: 8:00 AM to 3 PM • X-RAY • ULTRASOUND • BMD
DOCTOR, PLEASE PRINT YOUR NAME AS WELL					

X-RAY • MAMMOGRAPHY • ULTRASOUND • VASCULAR ULTRASOUND • BMD • CARDIOLOGY

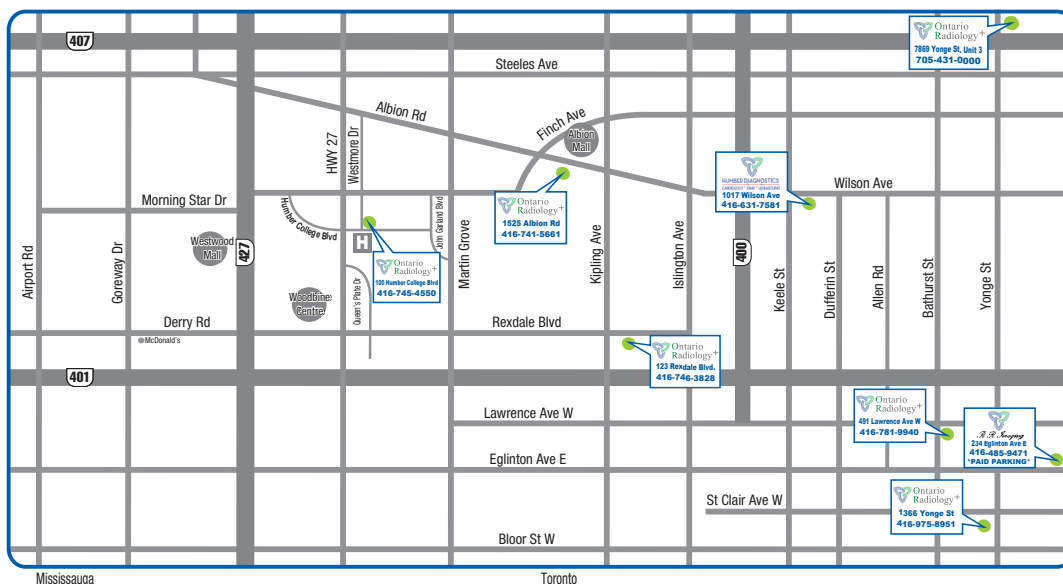
- ☐ 234 EGLINTON AVE E - TO MAKE APPT. CALL 416-485-9471
- ☐ 491 LAWRENCE AVE W - TO MAKE APPT. CALL 416-781-9940
- ☐ 1017 WILSON AVE - TO MAKE APPT. CALL 416-631-7581
- ☐ 1525 ALBION RD - TO MAKE APPT. CALL 416-741-5661
- ☐ 100 HUMBER COLLEGE BLVD - TO MAKE APPT. CALL 416-745-4550
- ☐ 123 REXDALE BLVD - TO MAKE APPT. CALL 416-746-3828
- ☐ 7869 YONGE ST - TO MAKE APPT. CALL 705-431-0000
- ☐ 1366 YONGE ST - TO MAKE APPT. CALL 416-975-8951

Appointment Date and Time

Date: _____

Time: _____

Cancellation should be made 24 hours before appointment.



MAMMOGRAPHY PREPARATIONS

NO POWDER OR DEODORANT

ULTRASOUND PREPARATIONS

ABDOMEN ULTRASOUND

- FAST FOR 8 HOURS, EAT A FAT FREE DINNER THE NIGHT BEFORE YOUR APPOINTMENT
- NO DAIRY PRODUCTS OR FRIED FOODS
- NO CARBONATED DRINKS 12 HOURS BEFORE YOUR APPOINTMENT
- NOTHING TO EAT OR DRINK AFTER MIDNIGHT THE NIGHT BEFORE EXCEPT WATER
- DO NOT EAT BREAKFAST

PELVIS ULTRASOUND (ALL TYPES)

- DRINK 4-5 GLASSES OF WATER (OR 2 SMALL BOTTLES) OF CLEAR FLUID **TO BE FINISHED ONE HOUR BEFORE** YOUR APPOINTMENT (WATER, JUICE, BLACK COFFEE OR BLACK TEA)
- DO NOT VOID - A FULL BLADDER IS NECESSARY FOR THE EXAMINATION
- NO FASTING NECESSARY

ABDOMEN AND PELVIS ULTRASOUND TOGETHER

- EAT A FAT FREE DINNER THE NIGHT BEFORE YOUR APPOINTMENT
- NO DAIRY PRODUCTS OR FRIED FOODS
- NOTHING TO EAT AFTER MIDNIGHT THE NIGHT BEFORE
- DRINK 4-5 GLASSES OF WATER (OR 2 SMALL BOTTLES) OF CLEAR FLUID **TO BE FINISHED ONE HOUR BEFORE** YOUR APPOINTMENT (WATER, JUICE, BLACK COFFEE OR BLACK TEA)
- DO NOT VOID - A FULL BLADDER IS NECESSARY FOR THE EXAMINATION

OBSTETRICAL ULTRASOUND

- FOR LESS THAN 12 WEEKS: DRINK 4-5 GLASSES OF WATER (OR 2 SMALL BOTTLES) OF CLEAR FLUID **TO BE FINISHED ONE HOUR BEFORE** YOUR APPOINTMENT (WATER, JUICE, BLACK COFFEE OR BLACK TEA). YOU MUST EAT BREAKFAST/LUNCH
- FOR 12/18 WEEKS/FOR OVER 18 WEEKS DRINK 2 GLASSES (OR 1 SMALL BOTTLE) OF CLEAR FLUID **TO BE FINISHED ONE HOUR BEFORE** YOUR APPOINTMENT (WATER, JUICE, BLACK COFFEE OR BLACK TEA). YOU MUST EAT BREAKFAST/LUNCH

LIVER ULTRASOUND

- FAST FOR AT LEAST 4 HOURS BEFORE THE EXAMINATION.

NO PREPARATION IS REQUIRED FOR FOLLOWING

- SCROTAL/TESTICULAR ULTRASOUND
- THYROID ULTRASOUND
- MUSCULOSKELETAL ULTRASOUND (ANY TYPE)
- BREAST ULTRASOUND

NUCHAL TRANSLUCENCY - IPS

- DRINK 3 GLASSES OF WATER (OR 1.5 SMALL BOTTLES) OF CLEAR FLUID **TO BE FINISHED ONE HOUR BEFORE** YOUR APPOINTMENT (WATER, JUICE, BLACK COFFEE OR BLACK TEA).
- YOU MUST BRING ALL THE PAPERS FROM YOUR DOCTOR (BLOOD WORK REQUISITION, I.P.S. SCREENING PAPER, ETC.) WITH YOU FOR YOUR APPOINTMENT

PROSTATE -TRANSRECTAL ULTRASOUND

- PURCHASE A **FLEET ENEMA** FROM THE PHARMACY AND FOLLOW THE INSTRUCTIONS IN THE PACKAGE
- SELF ADMINISTER THE ENEMA 2 HOURS BEFORE YOUR APPOINTMENT
- DRINK 4-5 GLASSES OF WATER (OR 2 SMALL BOTTLES) OF CLEAR FLUID **TO BE FINISHED ONE HOUR BEFORE** YOUR APPOINTMENT (WATER, JUICE, BLACK COFFEE OR BLACK TEA).
- DO NOT VOID

HYSTEROSONOGRAM

- DRINK 3 GLASSES OF WATER (OR 1.5 SMALL BOTTLES) OF CLEAR FLUID **TO BE FINISHED ONE HOUR BEFORE** YOUR APPOINTMENT (WATER, JUICE, BLACK COFFEE OR BLACK TEA).
- OCCASIONALLY, PATIENT MIGHT EXPERIENCE SOME CRAMPING DURING OR AFTER HYSTEROSONOGRAM. SHE MAY TAKE 1-2 TABLETS OF IBUPROFEN (TYLENOL OR ADVIL) 1 HOUR BEFORE OR AFTER THE PROCEDURE.

ALL BARIUM STUDIES

- NOTHING TO EAT OR DRINK 12 HOURS PRIOR TO THE TEST

DIAGNOSTIC TEST PREPARATIONS

EXERCISE STRESS TEST GXT / ECG / ECHO

- LIGHT BREAKFAST / LUNCH ON THE DAY OF TEST
- WEAR COMFORTABLE SHOES, T-SHIRTS, SHORTS OR PANTS
- NO SMOKING 1 HOUR PRIOR TO TEST
- BRING ALL CURRENT MEDICATIONS, AND CHECK WITH YOUR PHYSICIAN REGARDING THE DISCONTINUATION OF ANY RELATED MEDICATION.