Accurate Imaging Diagnostics
31 Disera Drive Unit 200, Thornhill, ON L4J 0A7
Tel: (905) 763-0009| Fax: (905) 763-0001

PATIENT INFORMATION

Last Name:_____
First Name:_____
H.C: _____Sex:_____
Tel: (_____) - _____-_____ Date Of Birth: MM/DD/YYYY

REFERRAL INFORMATION

☐ Urgent
☐ Routine

Physician:_____
Signature:_____

Tel: (_____) - _____- _____
Fax: (_____) - _____- _____

Clinical Information:_____
_____

Date LMP: MM /DD /YYYY
(For gyne & obstetric only)

DIGITAL X-RAY (Walk-in appointments accepted)

HEAD & NECK
- ☐ Skull
- ☐ Sinuses
- ☐ Adenoids
- ☐ Neck for Soft Tissues
- ☐ Sella Turcica
- ☐ Mastoids
- ☐ Facial Bones
- ☐ Nose
- ☐ Orbits
- ☐ Mandible
- ☐ T.M. Joints

ABDOMEN
- ☐ Single
- ☐ Acute

CHEST
- ☐ Chest PA
- ☐ Chest PA & LAT
- ☐ Ribs (☐L ☐R)
- ☐ Sternum
- ☐ Sterno-Clavicular Joints

UPPER EXTREMITIES
L	R	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	A.C. Joints
☐	☐	Scapula
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Hand
☐	☐	Scaphoid
☐	☐	Fingers

1 2 3 4 5

SPINE & PELVIS
- ☐ Cervical Spine
- ☐ Dorsal Spine
- ☐ Lumbar Spine
- ☐ Sacrum / Coccyx
- ☐ S.I. Joints
- ☐ Pelvis

LOWER EXTREMITIES
L	R	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tibia-Fibula
☐	☐	Ankle
☐	☐	Foot
☐	☐	Os Calcis
☐	☐	Toe

1 2 3 4 5

☐ Other_____

To the best of my knowledge I`m not pregnant.

x _____

ULTRASOUND (By appointment)

GENERAL
- ☐ Abdomen
- ☐ Limited Pelvic (Bladder pre/post void)

FEMALE PELVIC
- ☐ Pelvis
- ☐ Transvaginal
- ☐ Hysterosonography

MALE PELVIC
- ☐ Male Pelvis (Includes bladder, prostate)
- ☐ Transrectal (Includes Transabdominal)

OBSTETRICAL
- ☐ Dating
- ☐ IPS Nuchal Translucency (11-14 wks)
- ☐ OBS Anatomy (18-20 wks)
- ☐ OBS (High-risk/problem)
- ☐ Biophysical profile (After 28 wks)
- ☐ Fetal Growth Follow-up
- ☐ Twin Series

SECOND OPINION MRI
Area _____
Clinical Question (required) _____
_____
☐ Original Report Attached (required)

SMALL PARTS
- ☐ Thyroid
- ☐ Neck
- ☐ Submandibular Gland
- ☐ Parotid Glands
- ☐ Breast (☐L ☐R)
- ☐ Axilla (☐L ☐R)
- ☐ Groin (☐L ☐R)
- ☐ Hernia (☐L ☐R)
- ☐ Testes/ Scrotum
- ☐ Abdominal wall
- ☐ Soft Tissue / Lump
- ☐ Other_____

MUSCULOSKELETAL
L	R	
☐	☐	Shoulder
☐	☐	Arm
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist & Hand
☐	☐	Finger (☐L ☐R)
☐	☐	Hip Joint/Greater Trochanter
☐	☐	Thigh
☐	☐	Knee/Pop Fossa
☐	☐	Calf
☐	☐	Achilles Tendon/Plantar Fascia
☐	☐	Foot / Ankle
☐	☐	Other Muscle

Areas_____
US Guided Procedure
☐ Aspiration 1 ☐ Aspiration 2 ☐ Others

BONE MINERAL DENSITY (BMD)/ DEXA SCAN

☐ Screening ☐ High Risk-Q: 12 M ☐ First Follow Up - Q: 36 M ☐ Follow Up – Q: 60 M ☐ Body Composition

ULTRASOUND INSTRUCTIONS

☐ ABDOMINAL
- Fast for 12 hours prior to test and fat free diet (no dairy, meat, eggs, or fried food) for 24 hours. Nothing by mouth until after examination. Examination is approx. 30 min.

☐ PELVIC / OBSTETRICAL / BLADDER EXAMINATION
- A full bladder is essential for these examinations. Do not empty your bladder for two hours before your appointment. Drink 4 full glasses (32 oz.) of liquid except milk. Please complete drinking your fluids at least 1 hour before your appointment.

☐ RENAL ONLY
- Drink 2 full glasses (16 oz.) of water prior to the examination. Do not void until after the examination.

☐ THYROID, TESTES, AND MUSCULOSKELETAL
- No preparation required.

ALL CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE
YOU MUST BRING THIS OR EQUIVALENT REQUISITION FORM TO THE APPOINTMENT
PLEASE BRING YOUR HEALTH CARD

This requisition form can be taken to any licensed facility including hospitals and IHFs, such as those listed on the IHF Program website:
http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx