

PATIENT INFORMATION

PATIENT NAME: _____
DATE OF BIRTH: _____ GENDER: M F
TELEPHONE (HOME/CELL) _____
ADDRESS: _____ POSTAL CODE: _____
EMAIL: _____
HEALTH CARD: _____ VC: _____
TELEPHONE (CELL) : _____
TELEPHONE (HOME): _____

**APPOINTMENT
DATE AND TIME:** _____

CLINICAL INFORMATION

REFERRED BY: _____ BILLING # _____
SIGNATURE: _____ ☐ STAT ☐ VERBAL

ULTRASOUND

GENERAL

- ☐ Abdominal - Complete
- ☐ Kidney, Ureters, Bladder
- ☐ Kidneys & Renal Arteries - Hypertension
- ☐ Adrenals
- ☐ Pelvic - Transabdominal
- ☐ Pelvic - Endovaginal
- ☐ Prostate
- ☐ TRUS (includes US kidneys)
- ☐ Bladder Capacity / Post Void Residual (PVR)

OBSTETRICS:

- ☐ 1st Trimester
- ☐ Nuchal Translucency
- ☐ FU Anatomy Scan
- ☐ 2nd/3rd trimester - Complete
- ☐ Fetal Presentation
- ☐ Placental Position
- ☐ BPP
- ☐ EFW - Centile
- ☐ Twins
- ☐ Rule out Ectopic

SMALL PARTS:

- R L
- ☐ Thyroid
 - ☐ Scrotal
 - ☐ Salivary
 - ☐ Shoulder
 - ☐ Elbow
 - ☐ Wrist
 - ☐ Hip
 - ☐ Knee
 - ☐ Ankle
 - ☐ Achilles
 - ☐ Plantar Fascia

Other _____

BREAST IMAGING

☐ ULTRASOUND



ULTRASOUND PREPARATIONS

ABDOMINAL ULTRASOUND

- Fat free dinner the night before examination.
- No dairy products or fried food.
- No carbonated drinks 12 hours prior to examination.
- Nothing to eat or drink after midnight.

PELVIC/OBSTETRICAL OR TRANSABDOMINAL PROSTATE

- Drink 6 large glasses (48 oz.) of clear fluids (water, juice, black coffee or tea).
- You must be finished drinking all 48 oz. of fluid 1 hr before examination
- DO NOT VOID - A full bladder is necessary for the examination.
- Please eat breakfast and lunch.

ABDOMINAL/PELVIC TOGETHER

- Fat free dinner the night before examination.
- Nothing to eat after midnight.
- Drink 6 large glasses (48 oz.) of clear fluids (water, juice, coffee or tea) one hour before examination).
- DO NOT VOID - A full bladder is necessary for the examination.

TRANSRECTAL PROSTATE ULTRASOUND PREPARATIONS:

- 1) Obtain FLEET ENEMA from the lab (free). Follow the instructions in the package. Take the enema 2 hours before the appointment time.
- 2) Drink 5 glasses of water 1 hour before examination DO NOT VOID (urinate) until the examination is completed.

ALL OTHER TESTS

No preparation required.

BONE DENSITY

BONE MINERAL DENSITY DEXA: HIP & SPINE

- ☐ High Risk - (Annually)
- ☐ Routine - (2nd test at 3 years post baseline/subsequent testing every 5 years)

DATE OF LAST TEST: _____

X R A Y

CHEST

- ☐ Chest PA & LAT
- ☐ Chest PA Ins/ Exp & Lat
- ☐ Chest PA
- ☐ Sternum
- ☐ SC Joints
- ☐ Ribs & Chest PA
- ☐ R ☐ L

Abdomen

- ☐ KUB
- ☐ KUB Constipation
- ☐ Acute Abdomen

UPPER EXTREMITIES

- R L
- ☐ Shoulder
 - ☐ Clavicle
 - ☐ AC Joints
 - ☐ Scapula
 - ☐ Humerus
 - ☐ Elbow
 - ☐ Forearm
 - ☐ Wrist
 - ☐ Scaphoid
 - ☐ Hand
 - ☐ Fingers 1 2 3 4 5

HEAD & NECK

- ☐ Sinuses
- ☐ Skull
- ☐ Sella Turcica
- ☐ Facial Bones
- ☐ Nose
- ☐ Mandible
- ☐ TM Joints
- ☐ Adenoids
- ☐ Mastoids
- ☐ Neck for Soft Tissue
- ☐ Internal Auditory Meati
- ☐ Orbits

LOWER EXTREMITIES

- R L
- ☐ Hip
 - ☐ Femur
 - ☐ Knee
 - ☐ Tibia & Fibula
 - ☐ Ankle
 - ☐ Foot
 - ☐ Calcaneus
 - ☐ Toes 1 2 3 4 5

SPINE & PELVIS

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Scoliosis Series
- ☐ Sacrum & Coccyx
- ☐ SI Joints Pelvis

SKELETAL SURVEY

- ☐ Arthritic
- ☐ Metastatic
- ☐ Bone Age

CARDIOVASCULAR TESTING

PLEASE BRING THIS REQUISITION AND YOUR HEALTH CARD.

CARDIOVASCULAR

CONSULTATIONS

☐ Cardiology Consultation

- ☐ First Available
- ☐ Dr. Doug Ng
- ☐ Dr. Irving Tiong

☐ Electrophysiology (EP)

- ☐ First Available
- ☐ Dr. Doug Ng
- ☐ Dr. Irving Tiong

☐ Internal Medicine

- ☐ Dr. Irving Tiong

CARDIOLOGY

- ☐ Echocardiogram
- ☐ Exercise Stress Echo
- ☐ Holter Monitor ☐ 48hrs ☐ 72hrs ☐ 1wk ☐ 2wks
- ☐ Resting ECG ☐ 12 ☐ 15 ☐ 18 (recommended for women) Lead
- ☐ Routine
- ☐ Other _____
- ☐ Exercise Stress Test
- ☐ Ambulatory Blood Pressure Monitoring (ABPM)
- ☐ Microvolt T-Wave Alternans (MTWA)

DIAGNOSTICS TEST PREPARATIONS

EXERCISE STRESS TEST (GXT / ECG / ECHO)

- ☐ Light breakfast / lunch on the day of test
- ☐ Wear comfortable shoes, T-shirt, shorts or pants
- ☐ No smoking 1 hour prior to testing
- ☐ Bring all your current medication and check with your physician regarding the discontinuation of any related medication.

INDICATIONS/CLINICAL INFORMATION

- | | |
|-------|--|
| _____ | <input type="checkbox"/> Chest Pain |
| _____ | <input type="checkbox"/> Shortness of Breath |
| _____ | <input type="checkbox"/> History of MI / Stroke |
| _____ | <input type="checkbox"/> Palpitations |
| _____ | <input type="checkbox"/> Heart Murmur |
| _____ | <input type="checkbox"/> Dizziness / Lightheadedness |
| _____ | <input type="checkbox"/> Syncope |
| _____ | <input type="checkbox"/> High BP |
| _____ | <input type="checkbox"/> High Cholesterol |
| _____ | <input type="checkbox"/> Diabetes |
| _____ | <input type="checkbox"/> Abnormal ECG |

Date: _____ MD: _____



HUMBER DIAGNOSTICS
 CARDIOLOGY • X-RAY • ULTRASOUND
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Hours of Operation

Monday - Thursday: 8 AM - 6 PM
 Friday: 8 AM - 5 PM
 Saturday: 8 AM - 3 PM