KENSINGTON DIAGNOSTIC IMAGING CENTRE

Canadian Association of Radiologists (CAR) and Ontario Breast Screening Program (OBSP) Accredited Facility

340 College Street, Suite 410, Toronto, Ontario M5T 3A9

Tel: 416-962-3202 Fax: 416-962-9653 Web: www.kensingtonhealth.org

To order requisition forms, call 416-962-3202.

REQUEST FOR EXAMINATION FORM

PATIENT NAME: ______________________ WEIGHT: ________ HEIGHT: ________ D.O.B.: ____________

PATIENT ADDRESS: ______________________ PATIENT PHONE #: ______________________

HEALTH CARD #: ______________________ THIRD PARTY PAYOR: ______________________ (If applicable) CLAIM#: ______________________

ULTRASOUND

SMALL PARTS
- ☐ SOFT TISSUE FACE & NECK
- ☐ THYROID

ABDOMEN/PELVIS
- ☐ ABDOMINAL COMPLETE
- ☐ KIDNEYS
- ☐ PELVIS
- ☐ PELVIS / TRANSVAGINAL
- ☐ PROSTATE
- ☐ SCROTAL
- ☐ HERNIA ☐ R ☐ L

OBSTETRICAL
- ☐ DATING
- ☐ NT (11-14 WKS)
- ☐ ANATOMIC (18-20 WKS)
- ☐ FETAL GROWTH FOLLOW-UP
- ☐ BIOPHYSICAL PROFILE

MUSCULOSKELETAL
- ☐ SHOULDER ☐ R ☐ L
- ☐ ELBOW ☐ R ☐ L
- ☐ WRIST ☐ R ☐ L
- ☐ HIP ☐ R ☐ L
- ☐ KNEE ☐ R ☐ L
- ☐ FOOT ☐ R ☐ L
- ☐ ACHILLES TENDON ☐ R ☐ L
- ☐ LUMPS + BUMPS ☐ R ☐ L
- ☐ OTHER ____________ ☐ R ☐ L

VASCULAR
- ☐ ABI ONLY
- ☐ CAROTID
- ☐ LOWER EXTREMITY
  - ☐ ARTERIAL ☐ R ☐ L
  - ☐ VENOUS ☐ R ☐ L
- ☐ UPPER EXTREMITY
  - ☐ ARTERIAL ☐ R ☐ L
  - ☐ VENOUS ☐ R ☐ L

BIOPSY
- ☐ THYROID
- ☐ OTHER ______________________

BREAST IMAGING
- ☐ ROUTINE SCREENING MAMMOGRAM
- ☐ BREAST ULTRASOUND ☐ R ☐ L
- ☐ DIAGNOSTIC MAMMOGRAM ☐ R ☐ L
- ☐ IMPLANTS ☐ YES ☐ NO

AND/OR CHECK REASON FOR TESTING

☐ LUMP ☐ DISCHARGE ☐ PAIN

R L

(indicate area of concern on diagram)

ontario breast screening program
a cancer care ontario program

☐ ADDITIONAL IMAGING IF TEST RESULT IS POSITIVE/ABNORMAL

X-RAY (no appointment required)

HEAD AND NECK
- ☐ FACIAL BONES
- ☐ MANDIBLE
- ☐ ORBITS FOR MRI
- ☐ SINUSES
- ☐ SKULL
- ☐ TM JOINTS
- ☐ ADENOIDS
- ☐ MASTOIDS
- ☐ NOSE
- ☐ SOFT TISSUE OF NECK

CHEST
- ☐ CHEST P.A.
- ☐ CHEST P.A. & LAT.
- ☐ RIBS & CHEST P.A. ☐ R ☐ L ☐ BIL
- ☐ STERNUM

ABDOMEN
- ☐ KUB
- ☐ ACUTE ABDOMEN

SPINE & PELVIS
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ SACRUM & COCCYX
- ☐ S.I. JOINTS
- ☐ PELVIS
- ☐ THORACOLUMBARSPINE (SCOLIOSIS)

SKELETAL SURVEY
- ☐ METASTATIC SERIES
- ☐ ARTHIRITIC SERIES
- ☐ BONE AGE

UPPER EXTREMITIES
- ☐ SHOULDER ☐ R ☐ L ☐ BIL
- ☐ CLAVICLE ☐ R ☐ L ☐ BIL
- ☐ ACROMIOCLAVICULAR (A.C.) JOINTS ☐ R ☐ L ☐ BIL
- ☐ STERNOCLAVICULAR JOINTS ☐ R ☐ L ☐ BIL
- ☐ SCAPULA ☐ R ☐ L ☐ BIL
- ☐ HUMERUS ☐ R ☐ L ☐ BIL
- ☐ ELBOW ☐ R ☐ L ☐ BIL
- ☐ FOREARM ☐ R ☐ L ☐ BIL
- ☐ WRIST ☐ R ☐ L ☐ BIL
- ☐ SCAPHOID ☐ R ☐ L ☐ BIL
- ☐ HAND ☐ R ☐ L ☐ BIL
- ☐ FINGERS ☐ R ☐ L ☐ BIL

Indicate area of concern (*Thumb is 1*): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

LOWER EXTREMITIES
- ☐ HIP ☐ R ☐ L ☐ BIL
- ☐ FEMUR ☐ R ☐ L ☐ BIL
- ☐ KNEE ☐ R ☐ L ☐ BIL
- ☐ TIBIA & FIBULA ☐ R ☐ L ☐ BIL
- ☐ ANKLE ☐ R ☐ L ☐ BIL
- ☐ FOOT ☐ R ☐ L ☐ BIL
- ☐ HEEL ☐ R ☐ L ☐ BIL
- ☐ TOES ☐ R ☐ L ☐ BIL

Indicate area of concern (*Big toe is 1*): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

APPOINTMENT

PLEASE ARRIVE AT LEAST 15 MINUTES BEFORE YOUR APPOINTMENT AND BRING THIS FORM AND YOUR OHIP CARD. IF YOU ARRIVE LATE YOU MAY BE REBOOKED FOR ANOTHER TIME. SEE REVERSE FOR EXAM PREPARATION INSTRUCTIONS

DAY	MONTH	YEAR	TIME

REFERRING PHYSICIAN INFORMATION

REFERRED BY

ADDRESS

PHONE# | FAX #

REFERRING PHYSICIAN'S SIGNATURE

PROVIDER ID #

CC REPORTS TO | DATE

CLINICAL HISTORY **(MANDATORY)** ☐ **STAT**

BONE MINERAL DENSITY (DEXA)
- ☐ BASELINE (1st BMD)
- ☐ LOW RISK
- ☐ HIGH RISK

PREVIOUS REQUIRED ☐ YES ☐ NO

WHERE: ______________________

WHEN: ______________________

INDICATION: ______________________

I DECLARE TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT. PATIENT'S SIGNATURE: ______________________ DATE: ________

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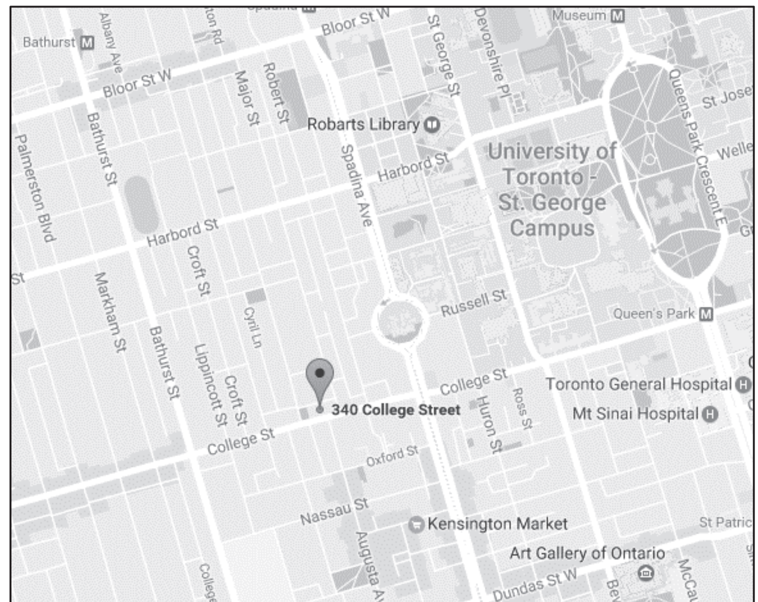

The Kensington Diagnostic Imaging Centre is wheelchair accessible.

PATIENT INSTRUCTIONS

If your test is not listed below, there is no specific preparation required.

ULTRASOUND

1. OBSTETRICAL AND PELVIC:
This test can only be done with the urinary bladder full. Drink 1 litre (four 8oz glasses) of water 1 hour before the appointment. Do not empty your bladder until after the test.

2. PELVIC ONLY – MALE & FEMALE:
Drink 1 litre (four 8oz glasses) of water 1 hour before the appointment. Do not empty your bladder until after the test.

3. ABDOMINAL:
No solid food or dairy products 8 hours before the exam.

4. COMBINED ABDOMINAL AND PELVIC:
No solid food or dairy products 8 hours before the exam. Drink 1 litre (four 8oz glasses) of water 1 hour prior to the appointment time. Do not empty your bladder until after the test.

MAMMOGRAM AND BREAST ULTRASOUND

Please wear a 2 piece outfit. Do not use deodorant or talcum powder on the day of the test.