

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

## PATIENT INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone : \_\_\_\_\_ Email : \_\_\_\_\_

Health Card# \_\_\_\_\_ Version Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Not Pregnant \_\_\_\_\_

**KINGSTON**  
 797 Princess St. Unit 422  
 Kingston, ON K7L 1G1  
 Ph: 613-548-3364  
 Fax: 613-548-8663  
 email: kis.kingston@gmail.com  
 www.kingstonimagingervices.ca

**LEGEND:**  
 X-Ray [X], Ultrasound [U/S], Vascular Ultrasound [V] Mammography [M], BMD,Fluoros [F]  
 Please refer to the back for Maps of locations

## CLINICAL HX

PHYSICIAN'S SIGNATURE: \_\_\_\_\_



DATE: \_\_\_\_\_

STAT  PHONE  FAX

## ULTRASOUND (APPOINTMENT RECOMMENDED)

GENERAL	OBSTETRICAL	MUSCULOSKETAL	SMALL PARTS	VASCULAR ULTRASOUND
<input type="checkbox"/> ABDOMEN & PELVIS <input type="checkbox"/> ABDOMEN <input type="checkbox"/> MALE PELVIS <input type="checkbox"/> FEMALE PELVIS <input type="checkbox"/> TRANSABDOMINAL <input type="checkbox"/> TRANSVAGINAL <input type="checkbox"/> PROSTATE <input type="checkbox"/> KIDNEY & BLADDER <input type="checkbox"/> OTHER _____	<input type="checkbox"/> 1ST TRIMESTER <input type="checkbox"/> EARLY OB FOLLOW-UP <input type="checkbox"/> 2ND/3RD TRIMESTER/HIGH RISK <input type="checkbox"/> ANATOMY SCAN (18-20 wks) <input type="checkbox"/> LMP _____	<input type="checkbox"/> SHOULDERS <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> ELBOWS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> WRISTS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HANDS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HIPS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> KNEES <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ANKLES <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ACHILLES <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> FEET <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LUMP <input type="checkbox"/> SPINE C T OR L REGION	<input type="checkbox"/> TESTICULAR <input type="checkbox"/> THYROID <input type="checkbox"/> GROIN / INGUINAL <input type="checkbox"/> PAROTID GLANDS <input type="checkbox"/> SALIVARY GLANDS <input type="checkbox"/> SUBMANDIBULAR GLANDS <input type="checkbox"/> NECK <input type="checkbox"/> SOFT TISSUE <input type="checkbox"/> OTHER _____	<input type="checkbox"/> CAROTID DOPPLER <input type="checkbox"/> LEG VEINS <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> DVT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> VARICOSE VEINS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LEG ARTERIES / AORTA <input type="checkbox"/> AORTA <input type="checkbox"/> OTHER _____

## X-RAY (NO APPOINTMENT REQUIRED)

CHEST	SPINE & PELVIS	HEAD AND NECK	UPPER EXTREMITIES	LOWER EXTREMITIES
<input type="checkbox"/> CHEST PA AND LAT <input type="checkbox"/> STERNUM <input type="checkbox"/> STERNOCLAVICULAR JOINTS <input type="checkbox"/> RIBS <input type="checkbox"/> R <input type="checkbox"/> L  <input type="checkbox"/> ABDOMEN <input type="checkbox"/> KUB <input type="checkbox"/> ACUTE (2 VIEWS) <input type="checkbox"/> OTHER _____	<input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBO-SACRAL <input type="checkbox"/> SACRUM & COCCYX <input type="checkbox"/> PELVIS <input type="checkbox"/> PELVIS AND HIPS <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> SI JOINTS  <input type="checkbox"/> SKELLETAL SURVEY <input type="checkbox"/> ARTHRITIC <input type="checkbox"/> METASTATIC	<input type="checkbox"/> SKULL <input type="checkbox"/> SINUSES <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> NASAL BONES <input type="checkbox"/> MANDIBLE <input type="checkbox"/> TM JOINTS <input type="checkbox"/> ADENOIDS <input type="checkbox"/> SOFT TISSUE NECK <input type="checkbox"/> ORBITS ( MRI )	<input type="checkbox"/> SHOULDER <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> CLAVICLE <input type="checkbox"/> AC JOINTS <input type="checkbox"/> SCAPULA <input type="checkbox"/> HUMERUS <input type="checkbox"/> ELBOW <input type="checkbox"/> FOREARM <input type="checkbox"/> WRIST <input type="checkbox"/> HAND <input type="checkbox"/> DIGITS 1 2 3 4 5 	<input type="checkbox"/> HIP <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> FEMUR <input type="checkbox"/> KNEE <input type="checkbox"/> TIBIA & FIBULA <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> CALCANEUS <input type="checkbox"/> TOES 1 2 3 4 5 

## BONE MINERAL DENSITOMETRY

**BASELINE**  
 FIRST TEST  
**FOLLOW UP**  
 HIGH RISK (1 YR)  
**ROUTINE**  
 3 YR. INITIAL FOLLOW UP FROM NORMAL BMD  
 5 YR. SUBSEQUENT FOLLOW-UP FROM NORMAL BMDS

## BREAST IMAGING

\*\*\* Currently Not Available \*\*\*

**MAMMOGRAPHY**  
 ROUTINE SCREENING  
 OBSP  
 DIAGNOSTIC \_\_\_\_\_  
 BREAST ULTRASOUND  R  L  B

**REGION OF INTEREST**  
 R  L

## OTHER PROCEDURES

\*\*\* Currently Not Available \*\*\*

UGI - UPPER GI  
 UGI SERIES & ABDOMINAL ULTRASOUND  
 SMALL BOWEL SERIES

## CARDIOVASCULAR

**GENERAL**  
 ECHOCARDIOGRAM  
 HOLTER MONITOR (48 hrs)



PLEASE ARRIVE 10 MINUTES EARLY FOR YOUR APPOINTMENT AND BRING YOUR HEALTH CARD AS WELL AS THIS FORM TO YOUR APPOINTMENT

Please provide 24 hours advance notice if you are unable to keep this appointment. Missed appointments may be subject to a non-refundable fee.

## ULTRASOUND PREPARATIONS

### ABDOMEN

- Do not eat or drink anything for 6 hours prior to examination.

### ABDOMEN/PELVIS

- Do not eat or drink anything for 6 hours prior to examination.
- One hour prior to the examination, finish drinking 4 8oz. of water. **DO NOT EMPTY YOUR BLADDER.**

### KIDNEY & BLADDER

- **Finish** drinking 4-8 oz (750 ml) of water 1 hour before examination. **DO NOT EMPTY YOUR BLADDER.**

### OBSTETRICAL (PREGNANCY) OR PELVIS

- One hour prior to the examination, **finish** drinking 4 8oz. of water. **DO NOT EMPTY YOUR BLADDER.** A full bladder is necessary for the examination.

**OTHER EXAMS:** No preparation required

## G.I. PREPARATIONS

### UPPER G.I. SERIES / BARIUM SWALLOW

- Nothing to eat or drink after midnight, the evening prior to examination
- ***No Breakfast, No Water, No Gum, No Candy***

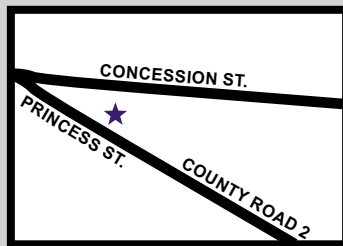
\*\* Diabetic patients: if on insulin, please consult your doctor for appropriate dosage.

## BONE DENSITOMETRY

- **DO NOT TAKE CALCIUM SUPPLEMENTS WITHIN 24 HOURS. APPOINTMENT SHOULD NOT BE BOOKED WITHIN 2 WEEKS OF HAVING ANY X-RAY EXAMS INVOLVING CONTRAST AGENTS OR HAVING A NUCLEAR MEDICINE APPOINTMENT.**

PLEASE WEAR SOMETHING WITHOUT METAL, BUTTONS OR ZIPPERS.

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### KINGSTON

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[www.kingstonimagingervices.ca](http://www.kingstonimagingervices.ca)

We are located on the North Side  
of Princess Street, between  
Pam's Flowers and Giant Tiger

### LEGEND:

X-Ray [X], Ultrasound [U/S], Vascular Ultrasound [V], Mammo [M], BMD, Fluoros [F]

"Disclaimer: This requisition form can be taken to any licensed facility providing health care services including hospitals and IHFs, such as those listed on the IHF website.

### NOTES: