



WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

76 Grenville Street,
Toronto, Ontario M5S 1B2

DEPARTMENT OF MEDICAL IMAGING

GENERAL INQUIRIES: 416-323-6080

ULTRASOUND: Fax: 416.323.6311 Tel: 416.323.6400 ext.4829

BREAST IMAGING: Fax: 416.323.6316 Tel: 416.323.6400 ext. 3080

GENERAL RADIOLOGY: Fax: 416.323.6316 Tel: 416.323.6400 ext. 3220

Name: _____

Address: _____

Telephone: _____ Alternate: _____

Health Card: _____ Version Code: _____

Date of Birth: ____ / ____ / ____
DD / MM / YYYY

ULTRASOUND

- Abdominal Ultrasound Transvaginal Ultrasound
- Sonohysterogram Pelvic Ultrasound
- NT Scan Obstetrical Ultrasound
- Anatomic Scan MSK
- NT Scan (11⁺³ – 13⁺³ weeks) + Anatomic Scan (18-20 weeks)
(Anatomic exam will be booked at the time of NT exam)
- Dating / NT (if GA appropriate)
- Assessment of fetal growth
- Biophysical Profile
- Cervix check Other: _____
- Thyroid/Neck Scrotum
- Doppler (Venous only), extremity: _____
- Other: _____

X-RAY

ABDOMEN:

- Single
- 2 Views

HEAD & NECK:

- Neck or Soft Tissues
- Orits pre MRI
- Other: _____

SPINE & PELVIC:

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Sacrum
- Coccyx
- SI Joint
- Pelvis
- Pelvis & Hips
- 3 Foot Spine
- Skeletal Survey
- Other: _____

UPPER EXTREMITIES:

- | | |
|--------------------------|--|
| R | L |
| <input type="checkbox"/> | <input type="checkbox"/> Clavicle |
| <input type="checkbox"/> | <input type="checkbox"/> A.C. Joints |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> Scapula |
| <input type="checkbox"/> | <input type="checkbox"/> Humerus |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> | <input type="checkbox"/> Forearm |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> | <input type="checkbox"/> Scaphoid |
| <input type="checkbox"/> | <input type="checkbox"/> Hand |
| <input type="checkbox"/> | <input type="checkbox"/> Digit 1 2 3 4 5 |

LOWER EXTREMITIES:

- | | |
|--------------------------|---|
| R | L |
| <input type="checkbox"/> | <input type="checkbox"/> Hip |
| <input type="checkbox"/> | <input type="checkbox"/> Femur |
| <input type="checkbox"/> | <input type="checkbox"/> Knee |
| <input type="checkbox"/> | <input type="checkbox"/> Tib, & Fib |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> | <input type="checkbox"/> Foot |
| <input type="checkbox"/> | <input type="checkbox"/> Toe 1 2 3 4 5 |
| <input type="checkbox"/> | <input type="checkbox"/> Calcaneus |
| <input type="checkbox"/> | <input type="checkbox"/> 3 feet or 4 feet leg |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ |

CHEST:

- Chest PA & LAT
- Chest PA-Immigration
- Ribs R L Bil
- Sterno-Clavicular JTS.
- Sternum
- Other:** _____
- Hysterosalpingograms by appt. only

For Registration: **Breast Imaging** 5th Floor
General Radiology, Ultrasound (other than Breast)
2nd Floor

Referring Physician Name: _____

(Please print:) _____

Address: _____

Tel: _____ **Fax:** _____

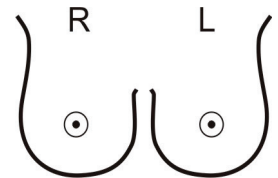
Appointment Date/Time: _____

- Urgent Routine Verbal

BREAST IMAGING - By appointment only

- Mammogram: Bil R L
 - Breast Ultrasound: Bil R L
 - Axilla Ultrasound: Bil R L
 - Stereotactic Core BX: Bil R L
 - U/S Core BX: Bil R L
 - Galactography: Bil R L
 - Consultation/Review of Outside Films
 - Pre-Op Localization
- Previous Mammogram & Ultrasound Yes No
- When & Where: _____
- Surgery Date and Time: _____

CLINICAL INFORMATION:



PHYSICIAN'S SIGNATURE: _____ **BILLING NUMBER:** _____



PLEASE SEE PREPARATION ON REVERSE SIDE INCOMPLETE REQUISITIONS WILL CAUSE A DELAY IN SERVICE
Form number F-5035 (3-2018)



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ULTRASOUND-PATIENT PREPARATION GUIDELINES

Abdomen

- Morning appointments: fast from midnight
- Afternoon appointments: fast following a light fat free breakfast at 0700 hours (e.g. dry toast and juice).

Combined abdomen and pelvis or abdomen for blood in urine

- Fast (as described above) AND refrain from voiding for 2 hours prior to the examination.

Pelvis (non-pregnant female or male)

- Follow a normal diet and refrain from voiding for 2 hours prior to the examination.
- Females declining Transvaginal (TV) examination may have to drink fluids in order to sufficiently distend their bladders for a trans-abdominal pelvic examination.

Pregnancy (Obstetrical)

- Eat and drink normally. *You are not required to drink extra fluids before your ultrasound.* Do not empty your bladder for one hour before your exam.

Hysterosonogram: please inform booking person of the first day of your last period

- If no previous WCH/MSH/UHN pelvic imaging refrain from voiding two hours prior to examination.
- If premenopausal (having periods) or postmenopausal on sequential hormone replacement (you have regular period-like bleeding), your exam should be done between day 6 and day 10 of your menstrual cycle.
- If postmenopausal and do not have periods, your test can be done at anytime.
- Take manufacturers recommended dose of ibuprofen (Advil or Motrin) or any other pain medication you normally take for menstrual pain 30 minutes prior to the scheduled examination time.

No special preparations are required for the following examinations:

- Leg and arm Doppler
- Thyroid
- Testicular (scrotal)

ACCREDITED BY CANADIAN ASSOCIATION OF RADIOLOGISTS ONTARIO BREAST SCREENING PROGRAM (OBSP) SITE

BREAST IMAGING-PATIENT PREPARATION GUIDELINES

On the day of examination, after showering, DO NOT use deodorant, anti-perspirant, or talcum powder on underarms or on chest. The particles on these products may show up on the mammogram causing false findings. Please wear a 2 piece outfit for comfort.

BREAST ULTRASOUND

On the day of examination, after showering, DO NOT use deodorant, anti-perspirant, or talcum powder on underarms or on chest. Please wear a 2 piece outfit for comfort.

BIOPSY, ASPIRATION AND GALACTOGRAPHY

Please call 416-323-6400 ext. 4315; 4512 for further instructions.

