MIDLAND RADIOLOGY & ULTRASOUND

X 光及超音波診斷 鴻運中心

Clinic Hours
Mon to Fri: 9 a.m. – 6 p.m.
Sat: 9 a.m. – 2 p.m.
Sun & Public Holidays closed

3833 Midland Avenue, Evergold Centre, Suite G, Scarborough ON M1V 5L6 **Tel**: **(416) 321-9243** **Fax: (416) 321-1650**

Please provide 24 hours notice for any cancellations. Please bring this requisition form and your valid Health Card.
Reports will be sent to referring physicians within 2-3 days. Urgent cases will be forwarded as soon as possible.

X-RAY

By Appointment Only
G.I. Tract
(Double Contrast)
☐ Ba Swallow
☐ Upper G.I. Series
☐ G.I. & Small Bowel

Abdomen
☐ Plain Film (KUB)
☐ Acute (3 views)

Head & Neck
☐ Skull
☐ Sinuses
☐ Adenoids
☐ Soft Tissue of Neck
☐ Mastoids
☐ Facial Bones
☐ Nasal Bones
☐ Orbits
☐ Mandible
☐ T.M. Joints

Chest
☐ Chest
☐ Ribs & Chest P.A.
☐R ☐L
☐ Sternum
☐ Sterno-clavicular Joints
☐ Thoracic Inlet

Spine & Pelvis
☐ Cervical Spine
☐ Dorsal Spine
☐ Scoliosis Series
☐ Lumbo-sacral Spine
☐ L/S Spine, Pelvis & S.I. Joints
☐ Sacrum & Coccyx
☐ S.I. Joints
☐ Pelvis & Hips

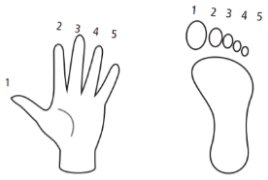
Skeletal Survey
☐ Metastatic Series
☐ Arthritic Series

Upper Extremities

R	L	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	A.C. Joint
☐	☐	Scapula
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Fingers 1 2 3 4 5

Lower Extremities

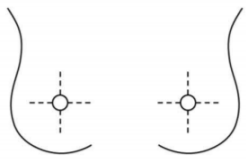
R	L	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tib & Fib
☐	☐	Ankle
☐	☐	Ankle incl. Stress Views
☐	☐	Foot
☐	☐	Os Calcis
☐	☐	Toes 1 2 3 4 5



☐ **8. BREAST ULTRASOUND**

R	L	Bilateral
☐	☐	☐

Right Left



ULTRASOUND

☐ **1. Abdomen**
☐ G.B. & Biliary System
☐ Liver
☐ Pancreas
☐ Spleen
☐ Aorta & IVC
☐ Kidneys
☐ **2. Pelvis/Transvaginal**
☐ **3. Prostate and Urinary Bladder**
☐ Transrectal
☐ **4. Obstetrical**
☐ Early Dating
☐ NT Scan
☐ Routine 2nd Trimester
☐ High Risk OB ☐ BPP

☐ **5. Musculoskeletal**

R	L	Bilateral	
☐	☐	☐	Shoulder
☐	☐	☐	Elbow
☐	☐	☐	Wrist
☐	☐	☐	Hip
☐	☐	☐	Knee
☐	☐	☐	Ankle/Heel
☐	☐	☐	Soft Tissue

☐ **6. Small Parts**
☐ Thyroid
☐ Testes/Scrotum
☐ **7. Others**

X-Ray Pregnancy Release: I declare, to the best of my knowledge, that I am **NOT** presently pregnant. _____
Signature of Patient

Clinical History:

_____
_____
_____
_____

Referred By:

Physician Name: _____
Signature: _____
Date: _____ ☐ **STAT** ☐ **VERBAL**
CC: _____

Patient Info:

Last Name: _____
First Name: _____
Birthdate (DD/MM/YYYY): _____
Health Card No: _____ Version:_____

Address: _____
_____
Telephone: _____

Appointment:

Date: _____ Time: _____