

FREE PARKING • SAME DAY APPOINTMENTS AVAILABLE

MARKHAM IMAGING CONSULTANTS

110 Copper Creek Drive, Suite 202
(Boxgrove Plaza) Markham, ON L6B 0P9
Tel: 905-471-6996 Fax: 905-471-5979

RADIOLOGIST ON SITE • SAME DAY REPORTING

STOUFFVILLE RADIOLOGICAL SERVICES

6212 Main St., Suite 201
Stouffville, ON L4A 2S5
Tel: 905-640-2243 Fax: 905-640-4452

www.markhamradiology.com

OWNED AND OPERATED BY THE MARKHAM STOUFFVILLE
HOSPITAL RADIOLOGISTS:

C. Stephen, M.D., FRCPC
J. Kan, M.D., FRCPC
M. Steirman, M.D., FRCPC
M.K. McLennan, M.D., FRCPC
T. Chung, M.D., FRCPC

M. Mehta, M.D., FRCPC
C. DeSequeira, M.D., FRCPC
J. Melindok, M.D., FRCPC
A. Sharif, M.D., FRCPC
P. Choi, M.D., FRCPC
S. Toor, M.D., FRCPC

Clinical Information & Reason For Study:

Patient Name:

Date of Birth:

Health No.:

Address:

Tel. No. (Home):

Tel. No. (Bus.):

Referring Physician & Signature:

Additional Reports To:

X-RAYS (WALK-IN)

ULTRASOUND (BY APPT)

HEAD & NECK	SPINE	EXTREMITIES	DIGITS	ULTRASOUND (BY APPT)
<input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Orbits / Pre-MRI <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> TM Joints <input type="checkbox"/> Soft Tissue / Neck <input type="checkbox"/> Adenoids	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbo Sacral <input type="checkbox"/> S.I. Joints <input type="checkbox"/> Sacrum / Coccyx <input type="checkbox"/> Pelvis <input type="checkbox"/> R. or <input type="checkbox"/> L. Hip <input type="checkbox"/> Scoliosis Series	<input type="checkbox"/> A.C. Joints <input type="checkbox"/> R. or <input type="checkbox"/> L. Clavicle <input type="checkbox"/> R. or <input type="checkbox"/> L. Shoulder <input type="checkbox"/> R. or <input type="checkbox"/> L. Scapula <input type="checkbox"/> R. or <input type="checkbox"/> L. Humerus <input type="checkbox"/> R. or <input type="checkbox"/> L. Elbow <input type="checkbox"/> R. or <input type="checkbox"/> L. Forearm <input type="checkbox"/> R. or <input type="checkbox"/> L. Wrist <input type="checkbox"/> R. or <input type="checkbox"/> L. Hand <input type="checkbox"/> R. or <input type="checkbox"/> L. Femur <input type="checkbox"/> R. or <input type="checkbox"/> L. Knee <input type="checkbox"/> R. or <input type="checkbox"/> L. Tib/Fib. <input type="checkbox"/> R. or <input type="checkbox"/> L. Ankle <input type="checkbox"/> R. or <input type="checkbox"/> L. Foot <input type="checkbox"/> R. or <input type="checkbox"/> L. Heel	<input type="checkbox"/> R <input type="checkbox"/> L Fingers <input type="checkbox"/> R <input type="checkbox"/> L Toes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> Abdominal <input type="checkbox"/> Pelvic <input type="checkbox"/> Transvaginal <input type="checkbox"/> Renal <input type="checkbox"/> Thyroid <input type="checkbox"/> Breast R L <input type="checkbox"/> Scrotum <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> R. <input type="checkbox"/> L. Shoulder <input type="checkbox"/> R. <input type="checkbox"/> L. Elbow <input type="checkbox"/> R. <input type="checkbox"/> L. Wrist <input type="checkbox"/> R. <input type="checkbox"/> L. Knee <input type="checkbox"/> R. <input type="checkbox"/> L. Achilles <input type="checkbox"/> Other
ABDOMEN <input type="checkbox"/> Single View <input type="checkbox"/> Acute (2-3 views)	CHEST <input type="checkbox"/> PA & Lateral <input type="checkbox"/> Ribs R L <input type="checkbox"/> Sternum <input type="checkbox"/> S.C. Joints	BMD Markham Office (by appointment)		Early Obstetrical: Full bladder required <input type="checkbox"/> Dating / Vialbility <input type="checkbox"/> IPS 2nd & 3rd Trimester OBS: No drinking necessary <input type="checkbox"/> 20 Week Anatomy Scan <input type="checkbox"/> Growth <input type="checkbox"/> Biophysical Profile Vascular <input type="checkbox"/> Carotid <input type="checkbox"/> Arterial Legs <input type="checkbox"/> Venous (DVT) R L
			Markham Office (by appointment)	
			<input type="checkbox"/> Baseline (1st Exam) <input type="checkbox"/> Routine (1 per 5 years) <input type="checkbox"/> High Risk (1 per year)	
			DATE OF LAST BMD EXAM	

**ALWAYS BRING YOUR HEALTH CARD & REQUISITION;
PLEASE CALL 24 HOURS IN ADVANCE OF ANY CANCELLATION OR PATIENTS MAY BE CHARGED**

***ULTRASOUND INSTRUCTIONS ON BACK**

RADIOLOGIST ON SITE • FEMALE TECHS • PLEASE BE ON TIME FOR YOUR APPOINTMENT OR YOU MAY BE REBOOKED

WE ACCEPT ALL MEDICAL REQUISITIONS!

PREPARATION FOR ULTRASOUND EXAMS

PLEASE READ CAREFULLY & BRING THIS PAPER WITH YOU

Please follow instructions carefully, otherwise your examination may need to be re-booked or repeated at a later date.

PREGNANCY ULTRASOUNDS

- ★ A **FULL BLADDER** is required for all **EARLY (<12 WEEKS)** pregnancy ultrasounds.
- ★ No drinking is required for 2nd or 3rd trimester ultrasounds.

RENAL AND PELVIC ULTRASOUNDS

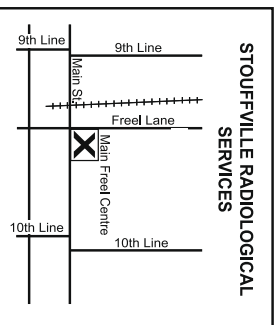
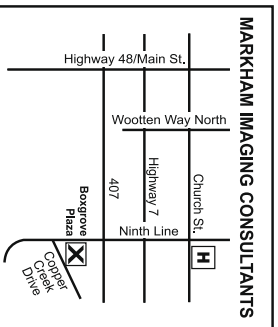
- ★ A **FULL BLADDER** is required for these exams. If your bladder is not full, your waiting time may be increased or you may need to rebook.
- ★ Please **FINISH DRINKING 4 large glasses (32oz) of WATER ONLY, 1HOUR** prior to the exam.
- ★ **DO NOT** empty your bladder after drinking.

ABDOMEN ULTRASOUND

- ★ An **EMPTY STOMACH** is required for this exam. **NOTHING** to eat or drink after midnight before the test.

ABDOMEN / PELVIC COMBINATION ULTRASOUND

- ★ An **EMPTY STOMACH AND A FULL BLADDER** is required.



FREE PARKING