

Patient Last Name \_\_\_\_\_ Patient First Name \_\_\_\_\_ Referring Physician Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
OHIP# \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_  
 WSIB  Non-OHIP/Third-Party Claim# \_\_\_\_\_ Injury Date \_\_\_\_\_ Company Name \_\_\_\_\_

**MRI**  **CT**  **Area to be scanned** \_\_\_\_\_

History of kidney disease? Yes  No  Creatinine \_\_\_\_\_ GFR \_\_\_\_\_ Date of last test \_\_\_\_\_  
Last Menstrual Cycle \_\_\_\_\_ Any allergies \_\_\_\_\_ Any previous exams \_\_\_\_\_  
Any previous surgeries \_\_\_\_\_ Previous reaction to IV contrast? (For CT Patients) Yes  No

**Does the patient have any of the following? (For MRI patients)**

Aneurysm Clips Yes  No  Artificial Cardiac Valve Yes  No  Cardiac Pacemaker Yes  No  Cochlear Implants Yes  No   
Coil or Stents Yes  No  Neurostimulator Yes  No  Retained Pacing Wires Yes  No  Shrapnel or Bullets Yes  No   
Other implanted devices: \_\_\_\_\_

**ULTRASOUND**

**Small Parts:** Soft Tissue Face & Neck  Thyroid   
**Abdomen/Pelvis:** Abdomen Complete  Abdomen Limited  \_\_\_\_\_ Kidney & Bladder  Pelvic  Pelvic & Transvaginal   
Pelvic & Transrectal of Prostate  Scrotal   
**Musculoskeletal:** Shoulder R  L  Knee R  L  Hip R  L  Other  Specify area \_\_\_\_\_  
Soft Tissue Lump  Specify area \_\_\_\_\_ Hernia Assessment  L  R  Inguinal  Abdominal Wall   
**Obstetrical:** Early Dating  Nuchal Translucency  Anatomic Assessment  Fetus Growth  Biophysical Profile  High Risk/Complication   
**Breast:** Bilateral  R  L

**X-RAY**

**Chest & Abdomen:** Chest PA & Lat  Ribs  R  L  Abdomen Single View  Abdomen Series   
**Spine:** Cervical  Thoracic  Lumbar  Sacrum & Coccyx  Scoliosis  AP  AP/LAT   
**Head & Neck:** Skull  Facial Bones  Nasal Bones  Mandible  Soft Tissue Neck   
**Skeletal Survey:** Metastatic  Bone Age Study  Other  \_\_\_\_\_  
**Upper Extremity:** Shoulder  R  L  Clavicle  R  L  Scapula  R  L  AC Joints (Bilateral)  Humerus  R  L   
Elbows  R  L  Forearm  R  L  Wrist  R  L  Scaphoid  R  L  Hand  R  L   
Fingers  R  L  # 1 2 3 4 5  
**Lower Extremity:** Pelvis  Hip  R  L  Femur  R  L  Knee  R  L  Knee/Standing  R  L  Bilat Standing PA Flexion   
Tibia/Fibula  R  L  Ankle  R  L  Foot  R  L  Calcaneus  R  L  Bilat Standing Leg Length   
Toe  R  L  # 1 2 3 4 5

**CARDIAC TESTING**

ECG  Echocardiography  Stress Test  Holter Monitor  24 Hr  48 Hr  78 Hr

**NON-OHIP SCREENING**

Prostate MRI  Coronary CTA & Calcium Scoring  Coronary Calcium Scoring   
MRI Breast Screening (not OBSP high risk)  MRI Breast Implant for rupture only

Doctor's Signature & Stamp