

Patient Information

Last Name _____ First Name _____

Birthdate / / OHIP - - VC Sex M F X

Address _____

City _____ Postal Code _____

Phone (day) () - (evening) () -

Referring Physician

Name _____ Phone () -

Address _____

Verbal Fax () - Copy to: _____

Signature _____

Chiropractic Referral? Radiologist Consult Required? Y N

Billing Number _____

Clinical Information

STAT REPORT REQUIRED

Verbal Contact Number: _____

Ultrasound

<p>Obstetrics Gynecology</p> <p><input type="checkbox"/> Female Pelvic / Transvaginal <input type="radio"/> Pelvic only <input type="radio"/> T/V only</p> <p><input type="checkbox"/> Dual Scan Series: NT Scan (11-14 wks.); Anatomical (18-20 wks.)</p> <p><input type="checkbox"/> NT Scan (11-14 wks.)</p> <p><input type="checkbox"/> Obstetrical</p> <p><input type="checkbox"/> Biophysical profile</p> <p><input type="checkbox"/> Twins</p> <p><input type="checkbox"/> Sonohysterography</p> <p><input type="checkbox"/> 3D Ultrasound</p> <p><input type="checkbox"/> Fallopian Tubes</p> <p><input type="checkbox"/> Follicular Monitoring</p>	<p>Vascular (Coxwell)</p> <p><input type="checkbox"/> Carotid Duplex</p> <p><input type="checkbox"/> Arterial Duplex <input type="radio"/> (upper) <input type="radio"/> (lower)</p> <p><input type="checkbox"/> Venous Duplex <input type="radio"/> (upper) <input type="radio"/> (lower)</p> <p><input type="checkbox"/> Vascular Screening (Carotid, Aorta, Legs)</p> <p><input type="checkbox"/> Venous Insufficiency</p> <p><input type="checkbox"/> Renial Arterial</p> <p><input type="checkbox"/> Diabetic Foot Assessment</p>	<p>Musculo-skeletal</p> <p>R L</p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulder/AC Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> Elbow</p> <p><input type="checkbox"/> <input type="checkbox"/> Wrist/Hand</p> <p><input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> Groin Mass/Inguinal Area</p> <p><input type="checkbox"/> <input type="checkbox"/> Hip</p> <p><input type="checkbox"/> <input type="checkbox"/> Hamstring</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee</p> <p><input type="checkbox"/> <input type="checkbox"/> Calf</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle/Foot</p> <p><input type="checkbox"/> <input type="checkbox"/> Achilles Tendon</p> <p><input type="checkbox"/> <input type="checkbox"/> Plantar Fascia</p>	<p>Abdominal/Pelvic</p> <p><input type="checkbox"/> Abdominal</p> <p><input type="checkbox"/> Male Pelvic (Pre- and Post-Void)</p> <p>Other Parts</p> <p><input type="checkbox"/> Thyroid and Neck</p> <p><input type="checkbox"/> Scrotal</p> <p><input type="checkbox"/> G.U. Tract <input type="radio"/> Kidneys <input type="radio"/> Bladder (Prostate)</p> <p><input type="checkbox"/> Transrectal / Prostate <input type="radio"/> Include Kidneys & Bladder</p>
---	---	--	---

LMP / /

Other (please specify) _____

Ultrasound appointments are at Spadina-Bloor Ultrasound - 720 Spadina Avenue, Unit 200, Toronto, M5S 2T9
 Other services are available at Insight's clinics across the GTA. See reverse for locations.

X-Ray


Please specify (right/left/bilateral & body part(s))

Breast Imaging

Screening Mammogram with OBSP

Mammogram
 Right Left Bilat.

Ultrasound
 Right Left Bilat.



Please indicate location and size of lesion

Bone Mineral Density


Baseline (One per lifetime) Prior BMD Date: / /

High risk annual

Low risk (3 years after baseline, subsequent studies after 5 years)

Risk category*: _____

*See www.health.on.gov.ca for BMD risk and MOH billing information.

CBMD 

Your Appointment:

Date: ___ / ___ / ___ Time: ___ am/pm
dd mm yyyy

Please bring your Ontario Health Card and/or UHIP number along with this requisition to your appointment. If you are unable to keep this appointment, please give at least 24 hours notice.
Please arrive 15 minutes prior to your appointment time.

Spadina-Bloor Ultrasound

200 - 720 Spadina Avenue
Toronto, ON M5S 2T9

☎ 416-519-9699

📠 416-519-6899

MAP HERE

Preparation and Instructions:

These instructions are IMPORTANT. Please follow them.

Ultrasound (U)

ABDOMEN: Includes studies of the GALL BLADDER, PANCREAS, SPLEEN, LIVER, KIDNEYS, and AORTA.

If your appointment is in the morning, do not eat or drink anything after midnight the night before. If your appointment is in the afternoon, for breakfast you may eat dry toast, black tea, black coffee, and juice up to 9 a.m. but have nothing to eat or drink after that. These instructions are important as we require you to have an empty stomach.

PELVIS: Includes TRANSVAGINAL (UTERUS, OVARIES, BLADDER) and PREGNANCY (OBSTETRICAL)

You must have a full bladder for this examination. Please start drinking 1 1/2 hours before your appointment and finish 45 minutes before the appointed time. You must drink 3 cups (24 oz / 750 mL) of fluid. This can include coffee, tea, juice, water etc. but not milk. **Do not go to the washroom.** We will try to examine you as soon as possible on arrival so that you won't be uncomfortable for too long. Eat the meal nearest your examination (there is no reason not to eat).

ABDOMEN and PELVIS combined examinations (ALSO G.U. TRACT)

You must have an empty stomach and full bladder. Do not eat anything within 12 hours of the examination. Finish drinking 3 cups (24 oz / 750 mL) of water (*and only water*) 45 minutes before your examination. **Do not go to the washroom.**

PROSTATE with TRANSRECTAL

Take a mild laxative the evening before your appointment (PROSTATE ONLY - OMIT LAXATIVE). Please start drinking 1 1/2 hours before your appointment and finish 45 minutes before the appointed time. You must drink 3 cups (24 oz / 750 mL) of water.

X-RAY (X)

If you are pregnant or think you might be, please talk to your doctor before having an x-ray. Women who think they may be pregnant should not have an x-ray during the last two weeks of their menstrual cycle.

Mammography (M)

On the day of the examination, after showering, please **do not use deodorant, anti-perspirant or talcum powder** on your chest or underarms since particles in these may show up on the mammogram.

Bone Mineral Density (B)

It is preferable to wear clothing without zippers or fasteners (e.g. jogging suit or leggings). On the day of the examination do not take calcium supplements or iron tablets until after the examination.

eReferrals

Our clinics now accept eReferrals! Find us on the [Ocean Healthmap](http://oceanhealthmap.ca) (oceanhealthmap.ca)

To sign up for OCEAN eReferral, complete the [online quick form](#) or email eReferral@ehealthce.ca.

Imaging Access Options

Ask us about our **PocketHealth** option to view your medical imaging online or request a DVD be sent to your physician.

In addition to Spadina-Bloor Ultrasound, Insight Diagnostic Imaging has five other radiology clinics. Services offered vary by location. Please see below for our locations and services offered.

Location	Services Offered
<input type="checkbox"/> Central Toronto Diagnostic Imaging*^• (Pape and Danforth) 658 Danforth Avenue, Main Floor, Toronto T 416-465-5735 F 416-465-1402	XUMB
<input type="checkbox"/> Coxwell Ultrasound (Coxwell and Danforth) 1577 Danforth Avenue, Unit 7, Toronto T 416-465-4679 F 416-465-2150	UV
<input type="checkbox"/> Mississauga Diagnostic Imaging and Breast Centre*^• (East of Cawthra) 801 Dundas Street East, Mississauga T 905-897-9711 F 905-897-9844	XUMB
<input type="checkbox"/> Victoria Terrace X-Ray & Ultrasound• (West side of Victoria Terrace Mall) 1448 Lawrence Avenue East, Suite 209 T 416-750-4555 F 416-750-4568	XUB
<input type="checkbox"/> (Don Mills) Insight Diagnostic Imaging 18 Wynford Drive, Suite 507, Toronto T 416-449-8289 F 416-449-9643	UM

* Ontario Breast Screening Program (OBSP) Site

^ Accredited for Bone Mineral Densitometry by the Ontario Association of Radiologists

• Accredited for Bone Mineral Densitometry by the Canadian Association of Radiologists