FINCHVIEW X-RAY & ULTRASOUND

1315 FINCH AVE. WEST, #114, TORONTO, ON M3J 2G6 TEL: (416) 633-4441 FAX: (416) 633-4597 finchview@promedproperty.com

Monday	9:00 am - 5:00 pm	Wednesday	9:00 am - 5:00 pm	Friday	9:00 am - 5:00 pm
Tuesday	9:00 am - 7:00 pm	Thursday	9:00 am - 7:00 pm	Saturday	9:00 am - 2:30 pm

ULTRASOUND
(By Appointment)

- ☐ Soft Tissue of Neck
- ☐ Thyroid
- ☐ R ☐ L Breast
- ☐ Abdomen
- ☐ Female Pelvis
- ☐ Transvaginal
- ☐ **Obstetrical**
  - ☐ Routine
  - ☐ IPS / NT
  - ☐ BPP
- ☐ Male Pelvis
- ☐ Testes/Scrotum

Prostate Ultrasound

- ☐ Transrectal (Incl. US Kidneys)
- ☐ Transabdominal

Musculo-Skeletal

- ☐ R ☐ L Shoulder
- ☐ R ☐ L Elbow
- ☐ R ☐ L Wrist
- ☐ R ☐ L Hand
- ☐ R ☐ L Hip
- ☐ R ☐ L Knee
- ☐ R ☐ L Ankle
- ☐ R ☐ L Foot
- ☐ Other: .....

X-RAY

Abdomen

- ☐ Plain Film (K.U.B.)
- ☐ Acute

Head & Neck

- ☐ Skull
- ☐ Adenoids
- ☐ Soft Tissues of Neck
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Orbits
- ☐ Mandible
- ☐ T.M. Joints

Skeletal Survey

- ☐ Metastatic Survey
- ☐ Arthritic Survey
- ☐ Bone Age

Chest

- ☐ Chest PA & LAT
- ☐ R ☐ L Ribs & Chest PA
- ☐ Immigration
- ☐ Sternum
- ☐ Sterno-Clavicular Joints

Spine & Pelvis

- ☐ Cervical Spine
- ☐ Dorsal Spine
- ☐ Scoliosis Series
- ☐ Lumbo-Sacral Spine
- ☐ Pelvis
- ☐ S.I. Joints
- ☐ Sacrum & Coccyx

- ☐ Other: .....
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Upper Extremities

- ☐ R ☐ L Shoulder
- ☐ R ☐ L Clavicle
- ☐ R ☐ L A.C. Joints
- ☐ R ☐ L Scapula
- ☐ R ☐ L Humerus
- ☐ R ☐ L Elbow
- ☐ R ☐ L Forearm
- ☐ R ☐ L Wrist
- ☐ R ☐ L Scaphold
- ☐ R ☐ L Hand
- ☐ R ☐ L Digits No.1 2 3 4 5

Lower Extremities

- ☐ R ☐ L Hip
- ☐ R ☐ L Femur
- ☐ R ☐ L Knee
- ☐ R ☐ L Tib & Fib
- ☐ R ☐ L Ankle
- ☐ R ☐ L Foot
- ☐ R ☐ L Calcaneus
- ☐ R ☐ L Toes No.1 2 3 4 5

Tech notes

Clinical Information: .....

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Referred by: ..... MD

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Copy To: .....

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☐ **BONE DENSITOMETRY**

CARDIAC EXAMINATIONS

- ☐ Echocardiography & colour assisted doppler
- ☐ Holter Monitoring (24 or 48)

PLEASE BRING THIS REQUISITION AND YOUR HEALTH CARD.

FOR PREPARATION INSTRUCTION & CLINIC LOCATION, PLEASE SEE OTHER SIDE.

Ont. Health Number	V.C	Patients Last Name (Please print or type)	Initials

Patients First Name	Patient's Birth Date	Patients Sex ☐ M ☐ F	Patients Phone No.

Patient's Address:

Date	Appointment Time

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website http:// www.health.gov.on.ca/en/public/programs/ihf/facilities:aspx

☐ **NOT PREGNANT** ☐ **VERBAL**