

Walk In
(if preparation not required)

Bathurst-Sheppard Diagnostic Imaging Centre

207 - 4430 Bathurst Street, North York, ON M3H 3S3

Phone: 416-226-6941 • Fax: 416-226-4270 • Email: tbaimaging207@gmail.com

For online booking go to: www.bathurstsheppardimaging.com

(PLEASE BRING YOUR HEALTH CARD AND THIS REQUISITION FORM)

OPEN 7 DAYS A WEEK



Patient:	Ref Doctor:	
Health Card No:	Phone No:	Fax No:
Date of Birth:	Billing No:	CC to:
Phone No:	Report Delivery Preference:	<input type="checkbox"/> Fax <input type="checkbox"/> HRM <input type="checkbox"/> Other
Clinical Notes:		

ULTRASOUND

GENERAL

- | | |
|--|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Female Pelvis-Transabdominal |
| <input type="checkbox"/> Male Pelvis | <input type="checkbox"/> Female Pelvis-Transvaginal |
| <input type="checkbox"/> Obstetrical < 16 wks. | <input type="checkbox"/> Prostate (Transrectal) |
| <input type="checkbox"/> Obstetrical > 16 wks. | <input type="checkbox"/> BPP / Growth / Doppler |
| | <input type="checkbox"/> NT (IPS) |

SMALL PARTS

- | | | |
|--|---|---|
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Submandibular Glands | <input type="checkbox"/> Parotid Glands |
| <input type="checkbox"/> Breast O R O L | <input type="checkbox"/> Axilla | <input type="checkbox"/> Chest Masses |
| <input type="checkbox"/> Testicular | <input type="checkbox"/> Inguinal Area | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Other Soft Tissue _____ | | |

MUSCULOSKELETAL

- | | | | | |
|---------------------------------------|---|---|--|--|
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Neck Muscles | <input type="checkbox"/> AC Joints | <input type="checkbox"/> Periscapular region |
| <input type="checkbox"/> Knee | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Thigh | <input type="checkbox"/> Calf | <input type="checkbox"/> Hamstring area |
| <input type="checkbox"/> Hip | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Hip Joint | <input type="checkbox"/> Gluteal area | <input type="checkbox"/> Lumbar/Scarl region |
| <input type="checkbox"/> Wrist & Hand | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Tendons | |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Forearm Muscles | <input type="checkbox"/> Other Musculoskeletal _____ | |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Achilles Tendons | | |
| <input type="checkbox"/> Foot | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Plantar Fascia | | |

VASCULAR

- | | |
|---|--|
| <input type="checkbox"/> Lower Limb Venous Doppler / Rule out DVT | |
| <input type="checkbox"/> Lower Limb Arterial Doppler | <input type="checkbox"/> CAROTID Doppler |
| <input type="checkbox"/> Upper Limb Venous Doppler | <input type="checkbox"/> AA Doppler |
| <input type="checkbox"/> Upper Limb Arterial Doppler | <input type="checkbox"/> Renal Duplex |

BONE MINERAL DENSITY

- | |
|--|
| <input type="checkbox"/> 1st Time Baseline |
| <input type="checkbox"/> Low Risk |
| <input type="checkbox"/> High Risk |
| <input type="checkbox"/> Date of Last BMD: |

X-RAY

- | | | | | |
|--|--|---|---|--|
| CHEST | SPINE & PELVIS | HEAD & NECK | UPPER EXTREMITIES | LOWER EXTREMITIES |
| <input type="checkbox"/> Chest PA and LAT | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Skull | <input type="checkbox"/> R <input type="checkbox"/> L Shoulder | <input type="checkbox"/> R <input type="checkbox"/> L Hip |
| <input type="checkbox"/> Sternum | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Sinuses | <input type="checkbox"/> R <input type="checkbox"/> L Clavicle | <input type="checkbox"/> R <input type="checkbox"/> L Femur |
| <input type="checkbox"/> Sternoclavicular-Joints | <input type="checkbox"/> Lumbar-Sacral | <input type="checkbox"/> Facial Bones | <input type="checkbox"/> R <input type="checkbox"/> L AC Joints | <input type="checkbox"/> R <input type="checkbox"/> L Knee |
| <input type="checkbox"/> Ribs O R O L | <input type="checkbox"/> Sacrum & Coccyx | <input type="checkbox"/> Nasal Bones | <input type="checkbox"/> R <input type="checkbox"/> L Scapula | <input type="checkbox"/> R <input type="checkbox"/> L Tibia & Fibula |
| <input type="checkbox"/> Chest PA (Immigration) | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Mandible | <input type="checkbox"/> R <input type="checkbox"/> L Humerus | <input type="checkbox"/> R <input type="checkbox"/> L Ankle |
| ABDOMEN | <input type="checkbox"/> Pelvis & Hips O R O L | <input type="checkbox"/> TM Joints | <input type="checkbox"/> R <input type="checkbox"/> L Elbow | <input type="checkbox"/> R <input type="checkbox"/> L Foot |
| <input type="checkbox"/> KUB | <input type="checkbox"/> SI Joints | <input type="checkbox"/> Adenoids | <input type="checkbox"/> R <input type="checkbox"/> L Forearm | <input type="checkbox"/> R <input type="checkbox"/> L Calcaneus |
| <input type="checkbox"/> Acute (2views) | SKELETAL SURVEY | <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> R <input type="checkbox"/> L Wrist | <input type="checkbox"/> R <input type="checkbox"/> L Toes |
| | <input type="checkbox"/> Arthritic | <input type="checkbox"/> Orbits | <input type="checkbox"/> R <input type="checkbox"/> L Hand | 1, 2, 3, 4, 5 |
| | <input type="checkbox"/> Metastatic | <input type="checkbox"/> Scoliosis Series | <input type="checkbox"/> R <input type="checkbox"/> L Digits | |
| | | | 1, 2, 3, 4, 5 | |

PREPARATIONS: (For Ultrasounds)

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>.

- Pelvis (F&M) & Obstetrical, < 16 wks** - Drink 4-5 glasses of water/clear fluids 1 hour before the appointment, do not void, full bladder is required during examination.
- Abdomen** - Eat fat free diet the night before examination. Only sips of plain water - if thirsty. Nothing to eat & Drink 8 hours prior to examination.
- Prostate (Transrectal)** - Take 2 Dulcolax tablets night before. Clear the bowel in the morning. Drink 4-5 glasses of clear fluid / water 1 hour before the appointment. **Do not void.**
- Abdomen & Pelvic Both** - Drink 4-5 glasses of plain water (No other fluid) about an hour before the appointment following 8 hours of fasting.