

Walk In  
(if preparation not required)

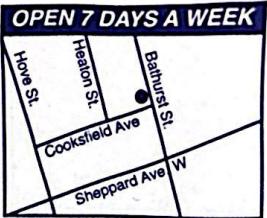
# Bathurst-Sheppard Diagnostic Imaging Centre

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

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For online booking go to: [www.bathurstsheppardimaging.com](http://www.bathurstsheppardimaging.com)

(PLEASE BRING YOUR HEALTH CARD AND THIS REQUISITION FORM)



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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> 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"/> Knee	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Thigh
<input type="checkbox"/> Hip	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hip Joint
<input type="checkbox"/> Wrist & Hand	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Carpal Tunnel
<input type="checkbox"/> Elbow	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Forearm Muscles
<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

<input type="checkbox"/> AC Joints	<input type="checkbox"/> Periscapular region
<input type="checkbox"/> Calf	<input type="checkbox"/> Hamstring area
<input type="checkbox"/> Gluteal area	<input type="checkbox"/> Lumbar/Scalp region
<input type="checkbox"/> Tendons	
<input type="checkbox"/> Other Musculoskeletal _____	

## 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 <input type="checkbox"/> R <input type="checkbox"/> 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
	<input type="checkbox"/> Pelvis & Hips <input type="checkbox"/> R <input type="checkbox"/> 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"/> SI Joints	<input type="checkbox"/> Adenoids	<input type="checkbox"/> R <input type="checkbox"/> L Forearm	<input type="checkbox"/> R <input type="checkbox"/> L Calcaneus
	<b>SKELETAL SURVEY</b>	<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"/> Orbita	<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.