



**CAMBRIDGE DIAGNOSTIC IMAGING**  
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# EXAM REQUEST

## OFFICE HOURS

Monday - Friday: 9:00 AM - 7:00 PM  
Saturday - Sunday: Closed

### PATIENT

### APPOINTMENT DATE /

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ TOWN/CITY \_\_\_\_\_ POSTAL \_\_\_\_\_

PHONE \_\_\_\_\_ HEALTH CARD # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
VERSION

DATE OF BIRTH \_\_\_\_\_ ☐ Male ☐ Female

### X-RAY

#### No Appointment Needed

#### ABDOMEN

- ☐ Plain Film  
(KUB)  
☐ Acute (3 views)

#### CHEST

- ☐ Chest  
☐ Ribs R ☐ L ☐ & Chest PA  
☐ Sternum  
☐ S.C. Joints  
☐ Immigration/Visa

#### SKELTAL SURVEY

- ☐ Metastatic Series  
☐ Arthritic Series  
☐ Scoliosis Series

#### HEAD AND NECK

- ☐ Skull  
☐ Sinuses  
☐ Soft Tissue  
Neck/Adenoids  
☐ Nasal Bones  
☐ Facial Bones  
☐ Mandible  
☐ T.M. Joints  
☐ Orbits ☐ R ☐ L  
☐ Mastoids

#### SPINE & PELVIS

- ☐ Cervical Spine  
☐ Thoracic Spine  
☐ Lumbo-Sacral Spine  
☐ Sacrum and & Coccyx  
☐ S.I. Joints  
☐ AP Pelvis  
☐ Pelvis & Hip ☐ R ☐ L

#### UPPER EXTREMITIES

- R L  
☐ ☐ Shoulder  
☐ ☐ Clavicle  
☐ ☐ A.C. Joints  
☐ ☐ Scapula  
☐ ☐ Humerus  
☐ ☐ Elbow  
☐ ☐ Forearm  
☐ ☐ Wrist  
☐ ☐ Scaphoid  
☐ ☐ Hand  
☐ ☐ Digits

#### LOWER EXTREMITIES

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

No. 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

### ULTRASOUND EXAMINATIONS

#### Appointment Needed

#### GENERAL

- ☐ Abdomen ☐ KUB  
☐ Abdomen & Pelvis  
☐ Portal Vein Doppler  
☐ Pelvis ☐ Pre-Void & Post-Void  
☐ Pelvis: (Includes transvaginal  
unless contraindicated)  
☐ Prostate ☐ Transrectal  
☐ Bilateral Breast ☐ R ☐ L  
☐ Testicular / Scrotal  
☐ Groin / Inguinal  
☐ Thyroid ☐ Head / Neck  
☐ Lumps

#### OBSTETRICAL

- ☐ Obstetrical - Dating  
☐ Dual Scan Series  
<14 WKS (NT  
MEASUREMENT/DATING etc.)  
18-20 WKS MORPHOLOGY  
SCAN ALSO  
☐ 18-20 weeks Routine  
☐ High Risk  
☐ R/o Ectopic  
☐ BPP  
☐ NT / IPS (11-14 weeks)  
☐ Other \_\_\_\_\_

#### MUSCULOSKELETAL

- R L  
☐ ☐ Hip Joints  
☐ ☐ Hamstrings  
☐ ☐ Knees  
☐ ☐ Achilles Tendons  
☐ ☐ Ankles  
☐ ☐ Foot  
☐ ☐ Plantar fascia

- R L  
☐ ☐ Shoulders  
☐ ☐ Elbows  
☐ ☐ Wrists  
☐ ☐ Hands  
☐ ☐ Other Muscle  
Areas  
☐ ☐ Other Soft  
Tissue  
☐ ☐ Lumps

#### VASCULAR ULTRASOUND

- R L  
☐ ☐ Carotid Arteries  
☐ ☐ Subclavian Arteries  
☐ ☐ Pseudo aneurysm /  
A-V fistula  
☐ ☐ Lower Limb Arteries  
☐ ☐ Lower Limb Veins  
☐ ☐ Upper Limb Arteries  
☐ ☐ Upper Limb Veins  
☐ ☐ Other

#### CLINICAL INFORMATION

#### SPECIAL REQUEST

- ☐ Stat  
☐ CD Requested

MD:

CC:

#### PREGNANCY RELEASE FORM

I declare to the best of my knowledge I  
am NOT presently pregnant

\_\_\_\_\_  
SIGNATURE

**PLEASE BRING YOUR HEALTH CARD AND THIS REQUISITION**  
**FEMALE TECHNOLOGISTS**  
**PLENTY OF FREE PARKING**

#### DR's OFFICE STAMP

Doctor, please print your name as well

**Please arrive 15 minutes before your appointment time for registration. Late arrival may require re-booking.**

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>