

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Res: \_\_\_\_\_ Other: \_\_\_\_\_

**Appointment Details**  
 Date: \_\_\_\_\_  
 Time: \_\_\_\_\_  
 Location: \_\_\_\_\_

**Refer to Preparation Instructions on Reverse**

Date of Birth: \_\_\_\_\_ mm/dd/yyyy     Age: \_\_\_\_\_      Male      Female  
 Insurance #: \_\_\_\_\_     WCB (Y / N) Other: \_\_\_\_\_

**Locations:**

6-2727 Parliament Ave Regina, SK S4S 6X5	214 University Park Dr Regina, SK S4V 1A3	6350 Rochdale Blvd Regina, SK S4X 4C2	650 Victoria Ave E, Regina, SK S4N 7E1	15 Thatcher Dr Moose Jaw, SK S6J 1L8
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<b>Significant Clinical History</b> _____ _____	<b>Stat Report Instructions:</b> <input type="checkbox"/> STAT fax report  <input type="checkbox"/> Send copies of x-ray with patient
Date of L.M.P. _____	Patient Signature: _____

**X-RAY Requested:**

**Ultrasound:** Preparation required for exams marked with \*

<b>General</b> <input type="checkbox"/> Neck (Salivary Glands/Lymph Nodes) <input type="checkbox"/> Thyroid <input type="checkbox"/> Abdomen* <input type="checkbox"/> Liver HCC Surveillance* (Specialist Referral) <input type="checkbox"/> Liver Elastography <input type="checkbox"/> Hernia <input type="checkbox"/> AAA Screen* <input type="checkbox"/> Renal/Bladder* <input type="checkbox"/> Appendix <input type="checkbox"/> Scrotal <input type="checkbox"/> Pelvis (Female)* <input type="checkbox"/> Follicle Tracking <input type="checkbox"/> Soft Tissue: _____	<b>Obstetrical</b> <input type="checkbox"/> Complete OBS Series* (Early, NT & Detailed) <b>1<sup>st</sup> Trimester</b> <input type="checkbox"/> Early Obstetric (<14 wks)* <input type="checkbox"/> Nuchal Translucency Screening* (11w3d to 14w0d) <b>2<sup>nd</sup> Trimester</b> <input type="checkbox"/> Detailed Fetal Anatomy (>18wks)* <input type="checkbox"/> add Uterine Artery Doppler <b>3<sup>rd</sup> Trimester (&gt;28 wks)</b> <input type="checkbox"/> Presentation <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Doppler <input type="checkbox"/> Growth <input type="checkbox"/> Other _____	<b>Venous</b> <input type="checkbox"/> Leg DVT R ___ L ___ <input type="checkbox"/> Arm DVT R ___ L ___  <b>Pediatrics</b> <input type="checkbox"/> Head <input type="checkbox"/> Hips <input type="checkbox"/> Spine <input type="checkbox"/> Pyloric Stenosis
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**Musculoskeletal Ultrasound:**  
 (May require x-rays)

R  L **Shoulder**

R  L **Elbow** Distal Biceps \_\_\_\_\_  
 Posterior \_\_\_\_\_ Medial \_\_\_\_\_ Lateral \_\_\_\_\_

R  L **Wrist** Dorsal \_\_\_\_\_ Volnar \_\_\_\_\_  
 Radial \_\_\_\_\_ Ulnar \_\_\_\_\_

R  L **Fingers:**  
 Trigger finger      Ganglion

R  L **Hip:**  
 Anterior      Lateral  
 Ischial (hamstrings)

R  L **Knee:**  
 (MRI required for ACL/PCL, cartilage and menisci)

R  L **Baker's Cyst**

R  L **Ankle:** Anterior \_\_\_\_\_ Posterior \_\_\_\_\_  
 Medial \_\_\_\_\_ Lateral \_\_\_\_\_

R  L **Foot:**  
 Morton's Neuroma  
 Plantar fascia

R  L **Lump/muscle (circle one)**  
 Location: \_\_\_\_\_

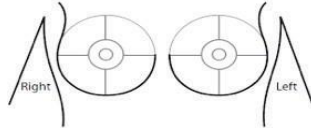
R  L **Nerve:** Type \_\_\_\_\_  
 Location: \_\_\_\_\_

R  L **Synovitis:** (joints)  
 Location \_\_\_\_\_

**Other** \_\_\_\_\_

**Breast Imaging**

<input type="checkbox"/> Routine Mammography	<input type="checkbox"/> Breast Ultrasound R ___ L ___
<input type="checkbox"/> Diagnostic Mammography (Please provide history)	<input type="checkbox"/> Axilla R ___ L ___



**Referring Practitioner Information**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Copy to: \_\_\_\_\_ Fax Copy \_\_\_\_\_  
 Signature: \_\_\_\_\_

Practitioner Stamp

Official Diagnostic Imaging provider for





## ALL EXAMINATIONS

Please bring your Health Insurance Card and another piece of identification with this form.  
If you have any questions about your exam, exam preparation, or need to change, or cancel your appointment, please contact Booking.

### ULTRASOUND

#### Abdominal:

**Adults:** Nothing by mouth for 8 hours before the exam. No smoking, candy or gum.

**Newborn:** Fast for 2 hours before the exam.

**0 to 3 years:** Fast for 4 hours before the exam.

**4 to 10 years:** Fast for 6 hours before the exam.

**11 years and older:** Fast for 8 hours before the exam.

**Medications may be taken with a sip of water if necessary.**

**Diabetic patients booked in early morning slots.**

#### Aorta for Aneurysm (AAA):

Nothing by mouth for 8 hours before the exam.

#### Pelvic:

**Adults:** Drink 1 litre of water 1 hour before the exam and **Do Not** empty bladder.

**0 to 3 years:** Encourage child to drink 8-12 oz of water 1 hour prior to the exam.

**3 to 10 years:** Encourage child to drink 12-20 oz of water 1 hour prior to exam and **Do Not** empty bladder.

**11 years and older:** 20-32 oz of water prior to the exam and **Do Not** empty bladder.

#### Abdominal/Pelvic:

Nothing to eat or drink for 8 hours prior except for 1 litre of water finished 1 hour before the exam.

**Do Not** empty bladder.

#### Renal:

**Adults:** Finish drinking 32 oz of water 1 hour before the exam and **Do Not** empty bladder.

**0 to 3 years:** Encourage child to drink 8-12 oz of water 1 hour prior to the exam.

**3 to 10 years:** Encourage child to drink 12-20 oz of water 1 hour prior to exam and **Do Not** empty bladder.

**11 years and older:** 20-32 oz of water prior to the exam and **Do Not** empty bladder.

#### Pyloric Stenosis:

Try to keep baby fasting for 3 hours, if possible. Bring bottle of formula or expressed milk.

#### Baby Hips:

No preparation is needed. Bring bottle of formula or expressed milk for use during the exam.

If baby does not take a bottle, mother should breast feed before the exam.

#### Baby Spine:

Bring bottle of formula or expressed milk.

#### Obstetric Ultrasound:

**05 to 14 weeks:** One hour before the exam, finish drinking 1 litre of water and **Do Not** empty bladder.

**14 to 16 weeks:** Finish drinking 1 litre of water 1 hour before the exam and **Do Not** empty bladder.

**Over 28 weeks:** Mother should have a light snack 30 minutes before the exam.

#### Nuchal Translucency:

Empty the bladder 2 hours before the exam. One hour before the exam, finish drinking 1 litre of water and

**Do Not** empty bladder.

### MAMMOGRAPHY

**Do Not** use perfume, deodorant, antiperspirant or talcum before the examination.

If you experience premenstrual breast tenderness, you may delay booking until tenderness has subsided.

Wear a two piece outfit.

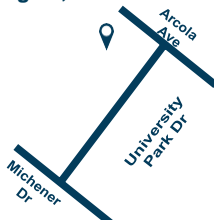
At the time of booking, you will be asked where your previous mammogram was done.

#### Locations:

6-2727 Parliament Ave  
Regina, SK S4S 6X5



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Regina, SK S4V 1A3



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