

YORKVIEW X-RAY & ULTRASOUND

3695 Keele St., 100 A, North York, ON, M3J 1N2

Tel: (416) 631-0007 Fax: (416) 631-0777

PATIENT NAME: _____

CLINICAL INFORMATION: _____

REFERRED BY: _____

MD SIGNATURE _____ **CC:** _____

I declare to the best of my knowledge I am not presently pregnant.
 Signature _____



X-RAY ULTRASOUND EXAMINATIONS

ABDOMEN

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

HEAD & NECK

- Skull
- Adenoids
- Soft Tissue of Neck
- Pituitary Fossa
- Nasal Bones
- Facial Bones
- Mandible
- T.M. Joints
- Orbits
- Other _____

CHEST

- Chest
- Ribs Lt Rt
- Sternum
- S.C. Joints

SPINE & PELVIS

- Cervical Spine
- Dorsal Spine
- Lumbo-Sacral Spine
- Sacrum & Coccyx
- S.I. Joints
- AP Pelvis
- Pelvis & Hip Lt Rt

SKELETAL SURVEY

- Metastatic Series
- Arthritis Series
- Metabolic Series

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>.

UPPER EXTREMITIES

- | | |
|---|-------------------------------|
| <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Both |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Both |
| <input type="checkbox"/> Clavicle | <input type="checkbox"/> Both |
| <input type="checkbox"/> A.C. Joints | <input type="checkbox"/> Both |
| <input type="checkbox"/> Scapula | <input type="checkbox"/> Both |
| <input type="checkbox"/> Humerus | <input type="checkbox"/> Both |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Both |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Both |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Both |
| <input type="checkbox"/> Scaphoid | <input type="checkbox"/> Both |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Both |
| <input type="checkbox"/> Fingers | <input type="checkbox"/> Both |
- No. 1 2 3 4 5

LOWER EXTREMITIES

- | | |
|---|-------------------------------|
| <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Both |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Both |
| <input type="checkbox"/> Femur | <input type="checkbox"/> Both |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Both |
| <input type="checkbox"/> Tibia & Fibula | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Both |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Both |
| <input type="checkbox"/> Calcaneus | <input type="checkbox"/> Both |
| <input type="checkbox"/> Toes | <input type="checkbox"/> Both |
- No. 1 2 3 4 5

GENERAL

- Abdomen
- Abdomen + Limited Pelvis
- Abdomen + Pelvis
- Pelvis: Pre-Post Void
- Female Pelvis
- Transvaginal
- Male Pelvis
- Prostate-Transrectal
- Testicular/Scrotal
- Thyroid
- Hernia _____
- Lt Rt Breast Both

OBSTETRICAL

- Obstetrical - Dating
- Obstetrical - Nuchal Translucency (IPS1/ IPS 2)
- Obstetrical - High Risk
- Obstetrical - Anatomy Scan
- Obstetrical + Biophysical Profile

MUSCULOSKELETAL / EXTREMITIES

- | | |
|---|-------------------------------|
| <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Both |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Both |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Both |
| <input type="checkbox"/> Wrist / Hand | <input type="checkbox"/> Both |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ankle / Achilles Tendon | <input type="checkbox"/> Both |
| <input type="checkbox"/> Thigh | <input type="checkbox"/> Both |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Both |
| <input type="checkbox"/> Foot / Plantar Fascia | <input type="checkbox"/> Both |
| <input type="checkbox"/> Soft Tissue _____ | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Both |

ULTRASOUND PREPARATIONS

ABDOMEN	<p>Morning appointment: Nothing to eat or drink after midnight. No breakfast.</p> <p>Afternoon appointment: Nothing to eat at least 6 hours before examination.</p>
PELVIC and PREGNANCY	<p>Drink 4 glasses of water (1.0 L) Finish drinking 60 minutes before the test. DO NOT GO TO THE WASHROOM</p>
ABDOMEN and PELVIC	<p>1) DO NOT EAT for 6 hours prior to examination.. 2) Drink 4 glasses of water (1.0 L) DO NOT GO TO THE WASHROOM</p>
PROSTATE-TRANSRECTAL	<p>1) Purchase fleet enema from the pharmacy. Follow the instructions in the package. Take the enema 2 hours before the appointment time. 2) Drink 4 large glasses of water (1.0 L) Finish drinking 60 minutes before the test. DO NOT GO TO THE WASHROOM</p>

PLEASE BRING THIS FORM AND YOUR HEALTH CARD