Radiant Medical Imaging

Clinic Hours
Mon to Fri: 9 a.m. – 6 p.m.
Sat: 9 a.m. – 2 p.m.
Sun & Public Holidays closed
X-Ray Starts 10 a.m.

****NEW ADDRESS: 385 Silver Star Blvd - Suite 209, Scarborough, ON M1V 0E3 Tel: (416) 321-9243 Fax: (416) 321-1650**

Please provide 24 hours notice for any cancellations. Please bring this requisition form and your valid Health Card.
Reports will be sent to referring physicians within 2-3 days. Urgent cases will be forwarded as soon as possible.

X-RAY*

(Starts 10:00 am Mon to Sat)

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

Head & Neck
- ☐ Skull
- ☐ Sinuses
- ☐ Adenoids
- ☐ Soft Tissue of Neck
- ☐ Mastoids
- ☐ Facial Bones
- ☐ Nasal Bones
- ☐ Orbits
- ☐ Mandible
- ☐ T.M. Joints

Chest
- ☐ Chest
- ☐ Ribs & Chest P.A.
  - ☐R ☐L
- ☐ Sternum
- ☐ Sterno-clavicular Joints
- ☐ Thoracic Inlet

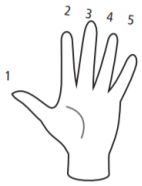
Skeletal Survey
- ☐ Metastatic Series
- ☐ Arthritic Series

Spine & Pelvis
- ☐ Cervical Spine
- ☐ Dorsal Spine
- ☐ Scoliosis Series
- ☐ Lumbo-sacral Spine
- ☐ L/S Spine, Pelvis & S.I. Joints
- ☐ Sacrum & Coccyx
- ☐ S.I. Joints
- ☐ Pelvis & Hips

Upper Extremities

R	L	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	A.C. Joint
☐	☐	Scapula
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Fingers

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5



Lower Extremities

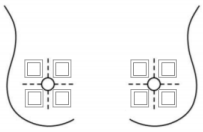
R	L	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tib & Fib
☐	☐	Ankle
☐	☐	Ankle incl. Stress Views
☐	☐	Foot
☐	☐	Os Calcis
☐	☐	Toes

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ **8. BREAST ULTRASOUND**

R	L	Bil.	Bil. Axilla
☐	☐	☐	☐

Right Left



ULTRASOUND

We accept walk-in patients

- ☐ **1. Abdomen (+Ltd. Pelvis if required)**
  - ☐ G.B. & Biliary System
  - ☐ Liver
  - ☐ Pancreas
  - ☐ Spleen
  - ☐ Aorta & IVC
  - ☐ Kidneys
- ☐ **2. Female Pelvis** ☐ **Transvaginal**
- ☐ **3. Prostate and Urinary Bladder**
  - ☐ Transrectal
- ☐ **4. Obstetrical**
  - ☐ Early Dating
  - ☐ NT Scan
  - ☐ Routine 2nd Trimester
  - ☐ Limited OB ☐ BPP
- ☐ **5. Musculoskeletal**

R	L	Bilateral	
☐	☐	☐	Shoulder
☐	☐	☐	Elbow
☐	☐	☐	Wrist
☐	☐	☐	Hip
☐	☐	☐	Knee
☐	☐	☐	Ankle/Heel
☐	☐	☐	Soft Tissue

- ☐ **6. Small Parts**
  - ☐ Thyroid
  - ☐ Neck
  - ☐ Testes/Scrotum
- ☐ **7. Others** _____

X-Ray Pregnancy Release: I declare, to the best of my knowledge, that I am **NOT** presently pregnant. _____
☐ **Lead Shielding** _____ *Signature of Patient*

Clinical History:

_____

_____

_____

Referred By:

Physician Name: _____

Signature: _____ Date: _____

☐ **STAT** ☐ **VERBAL CC:** _____

Patient Info:

Last Name: _____

First Name: _____

Birthdate (DD/MM/YYYY): _____

Health Card No: _____ Version: _____

Address: _____

_____

Telephone: _____

Appointment:

Date: _____ Time: _____