

# FREE PARKING • SAME DAY APPOINTMENTS AVAILABLE

**OWNED AND OPERATED BY THE MARKHAM STOUFFVILLE  
HOSPITAL RADIOLOGISTS:**

C. Stephen, M.D., FRCPC	C. DeSequeira, M.D., FRCPC	R. Hanna, M.D., FRCPC
J. Kan, M.D., FRCPC	J. Meindok, M.D., FRCPC	M. Kern, M.D., FRCPC
M. Steirman, M.D., FRCPC	A. Sharif, M.D., FRCPC	P. Yang, M.D., FRCPC
M.K. McLennan, M.D., FRCPC	P. Choi, M.D., FRCPC	K. Noble, M.D., FRCPC
T. Chung, M.D., FRCPC	S. Choy, M.D., FRCPC	
M. Mehta, M.D., FRCPC	S. Toor, M.D., FRCPC	

**MARKHAM IMAGING  
CONSULTANTS**

110 Copper Creek Drive, Suite 202  
(Boxgrove Plaza) Markham, ON L6B 0P9  
Tel: 905-471-6996 Fax: 905-471-5979

**STOUFFVILLE X-RAY  
AND ULTRASOUND**

6212 Main Street, Suite 102  
Stouffville, ON L4A 2S5  
Tel: 905-640-2243 Fax: 905-640-4452

www.markhamradiology.com

Clinical Information & Reason For Study:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Health No.: \_\_\_\_\_

Address: \_\_\_\_\_

Tel. No. (Home): \_\_\_\_\_

Tel. No. (Bus.): \_\_\_\_\_

Referring Physician & Signature / OHIP Billing# / Date: \_\_\_\_\_

Additional Reports To: \_\_\_\_\_

## X-RAYS (WALK-IN)

## ULTRASOUND (BY APPT)

HEAD & NECK	SPINE	EXTREMITIES	DIGITS	BMD	ULTRASOUND
<input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bone <input type="checkbox"/> Orbits / Pre-MRI <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> TM Joints <input type="checkbox"/> Soft Tissue / Neck <input type="checkbox"/> Adenoids	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbo Sacral <input type="checkbox"/> S.I. Joints <input type="checkbox"/> Sacrum / Coccyx <input type="checkbox"/> Pelvis <input type="checkbox"/> R. or <input type="checkbox"/> L. Hip <input type="checkbox"/> Scoliosis Series	<input type="checkbox"/> A.C. Joints <input type="checkbox"/> R. or <input type="checkbox"/> L. Clavicle <input type="checkbox"/> R. or <input type="checkbox"/> L. Shoulder <input type="checkbox"/> R. or <input type="checkbox"/> L. Scapula <input type="checkbox"/> R. or <input type="checkbox"/> L. Humerus <input type="checkbox"/> R. or <input type="checkbox"/> L. Elbow <input type="checkbox"/> R. or <input type="checkbox"/> L. Forearm <input type="checkbox"/> R. or <input type="checkbox"/> L. Wrist <input type="checkbox"/> R. or <input type="checkbox"/> L. Hand <input type="checkbox"/> Bone Age <input type="checkbox"/> R. or <input type="checkbox"/> L. Femur <input type="checkbox"/> R. or <input type="checkbox"/> L. Knee <input type="checkbox"/> R. or <input type="checkbox"/> L. Tib/fib. <input type="checkbox"/> R. or <input type="checkbox"/> L. Ankle <input type="checkbox"/> R. or <input type="checkbox"/> L. Foot <input type="checkbox"/> R. or <input type="checkbox"/> L. Heel	<input type="checkbox"/> R <input type="checkbox"/> L Fingers <input type="checkbox"/> R <input type="checkbox"/> L Toes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<b>BMD</b>	<input type="checkbox"/> Abdominal <input type="checkbox"/> Pelvic (Male) <input type="checkbox"/> Pelvic (Female) with Transvaginal (Unless contraindicated)  <input type="checkbox"/> Renal <input type="checkbox"/> Thyroid <input type="checkbox"/> Breast R L <input type="checkbox"/> Scotum <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> R <input type="checkbox"/> L. Shoulder <input type="checkbox"/> R <input type="checkbox"/> L. Elbow <input type="checkbox"/> R <input type="checkbox"/> L. Wrist <input type="checkbox"/> R <input type="checkbox"/> L. Knee <input type="checkbox"/> R <input type="checkbox"/> L. Achilles  <input type="checkbox"/> Other
<b>ABDOMEN</b>	<input type="checkbox"/> PA & Lateral <input type="checkbox"/> Ribs R L <input type="checkbox"/> Sternum <input type="checkbox"/> S.C. Joints		<input type="checkbox"/> Baseline (1st Exam) <input type="checkbox"/> Routine (1 per 5 years) <input type="checkbox"/> High Risk (1 per year)	<b>Markham Office</b> (by appointment)	<p><b>Early Obstetrical:</b> Full bladder required  <input type="checkbox"/> Dating / Viability  <input type="checkbox"/> IPS / FTS</p> <p><b>2nd &amp; 3rd Trimester OBS:</b> No drinking necessary  <input type="checkbox"/> 20 Week Anatomy Scan  <input type="checkbox"/> Growth  <input type="checkbox"/> Biophysical Profile</p> <p><b>Vascular</b>  <input type="checkbox"/> Carotid  <input type="checkbox"/> Arterial Legs  <input type="checkbox"/> Venous (DVT) R L</p>
<input type="checkbox"/> Single View <input type="checkbox"/> Acute (2-3 Views)			DATE OF LAST BMD EXAM _____		

**ALWAYS BRING YOUR HEALTH CARD & REQUISITION;  
PLEASE CALL 24 HOURS IN ADVANCE OF ANY CANCELLATION OR PATIENTS MAY BE CHARGED**

**\*ULTRASOUND INSTRUCTIONS ON BACK**

**RADIOLOGIST ON SITE • FEMALE TECHS • PLEASE BE ON TIME FOR YOUR APPOINTMENT OR YOU MAY BE REBOOKED**

**RADIOLOGIST ON SITE • SAME DAY REPORTING**