

**OWNED AND OPERATED BY THE MARKHAM STOUFFVILLE
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| | | |
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**STOUFFVILLE X-RAY
AND ULTRASOUND**

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www.markhamradiology.com

Clinical Information & Reason For Study:

Patient Name: _____

Date of Birth: _____

Health No.: _____

Referring Physician & Signature / OHIP Billing# / Date:

Address: _____

Tel. No. (Home): _____

Tel. No. (Bus.): _____

Additional Reports To: _____

X-RAYS (BY APPT)

ULTRASOUND (BY APPT)

| HEAD & NECK | SPINE | EXTREMITIES | DIGITS | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Skull <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 | <input type="checkbox"/> Abdominal <input type="checkbox"/> Pelvic (Male) <input type="checkbox"/> Pelvic (Female) with Transvaginal (Unless contraindicated) <input type="checkbox"/> Renal (Kidneys / Bladder) <input type="checkbox"/> Thyroid <input type="checkbox"/> Breast R L <input type="checkbox"/> Scrotum <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 _____ |
| | <p>CHEST</p> <input type="checkbox"/> PA & Lateral <input type="checkbox"/> Ribs R L <input type="checkbox"/> Sternum <input type="checkbox"/> S.C. Joints | | | <p>Early Obstetrical: Full bladder required <input type="checkbox"/> Dating / Viability <input type="checkbox"/> IPS / FTS</p> <p>2nd & 3rd Trimester OBS: No drinking necessary <input type="checkbox"/> 20 Week Anatomy Scan <input type="checkbox"/> Growth <input type="checkbox"/> Biophysical Profile</p> <p>Vascular <input type="checkbox"/> Carotid <input type="checkbox"/> Arterial Legs <input type="checkbox"/> Venous (DVT) R L</p> |
| <p>ABDOMEN</p> <input type="checkbox"/> Single View <input type="checkbox"/> Acute (2-3 Views) | | | <p>BMD</p> <p>Markham Office (by appointment)</p> <input type="checkbox"/> Baseline (1st Exam) <input type="checkbox"/> Routine (1 per 5 years) <input type="checkbox"/> High Risk (1 per year) <p>DATE OF LAST BMD EXAM _____</p> | |

**PREPARATION
FOR ULTRASOUND EXAMS
PLEASE READ CAREFULLY & BRING THIS PAPER WITH YOU**

Please follow instructions carefully, otherwise your examination may need to be re-booked or repeated at a later date.

PREGNANCY ULTRASOUNDS

- ★ A **FULL BLADDER** is required for all **EARLY (<14 WEEKS)** pregnancy ultrasounds.
- ★ No drinking is required for 2nd or 3rd trimester ultrasounds.

RENAL AND PELVIC ULTRASOUNDS

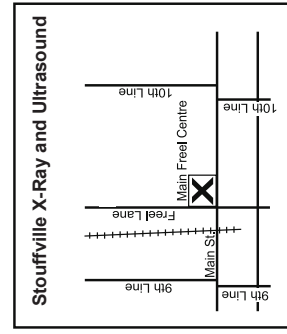
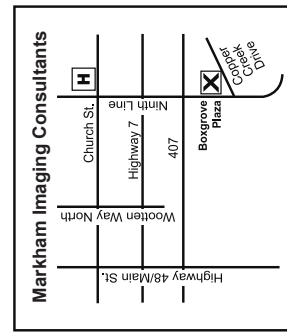
- ★ A **FULL BLADDER** is required for these exams. If your bladder is not full, your waiting time may be increased or you may need to rebook.
- ★ Please **FINISH DRINKING 4 large glasses (32oz) of WATER ONLY, 1HOUR** prior to the exam.
- ★ **DO NOT** empty your bladder after drinking.

ABDOMEN ULTRASOUND

- ★ An **EMPTY STOMACH** is required for this exam. **NOTHING** to eat or drink after midnight before the test.

ABDOMEN / PELVIC COMBINATION ULTRASOUND

- ★ An **EMPTY STOMACH AND A FULL BLADDER** is required.



FREE PARKING