DIAGNOSTIC IMAGING REQUISITION

RadiologyAssociates

Phone: 403-328-1122 Fax: 403-328-1218
Email: service@raimaging.net

☐ 1122 Scenic Drive South
☐ U3T MRI at U of L
☐ 65 Columbia Blvd West

www.lethbridgeradiology.com

PATIENT

APPOINTMENT DATE / TIME:

BRING VALID HEALTH CARE CARD & THIS FORM. If you are unable to attend your appointment, please call to cancel or reschedule at least 2 hours prior to your appointment. **NO SHOWS MAY BE CHARGED. CHILDREN ARE NOT ALLOWED IN EXAM ROOMS. CHILD CARE IS NOT PROVIDED**

NAME: (LAST) (FIRST) (MIDDLE) ☐ AHC #: ☐ OUT OF PROVINCE

ADDRESS: CITY: ☐ WCB ☐ PATIENT ☐ PRIVATE

POSTAL CODE: PROVINCE: AGE: DOB: (MM / DD / YEAR) LMP: (MM / DD / YEAR)

PHONE #: (HOME) (WORK / CELL) ☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ NO

REFERRAL

ORDERING PHYSICIAN: SEND COPY TO:

CLINIC NAME: CLINIC NAME:

FAX REPORTS TO #: FAX REPORTS TO #:

HISTORY & PROVISIONAL DIAGNOSIS:

☐ Wheelchair, walker, limited mobility, etc. (allow more time)

☐ Relevant prior imaging:_____ (LOCATION AND DATE OF EXAM)

_____ M.D.

EXAM

☐ **MAMMOGRAPHY**

☐ IMPLANTS (requires more time)

☐ PREVIOUS BREAST CANCER

On the day of the exam, wash off all deodorants, perfumes, powders and/or lotions under the arm and across the chest.

☐ **X-RAY** (No preparation required)

BODY PART:_____

☐ **BONE DENSITOMETRY**

Bring a list of all prescribed medications and amount of calcium and vitamin D in supplement form. No metal (including zippers and underwire bras) from the armpit down to just above the knees. If possible, remove bellybutton ring. No contrast exams (e.g., barium, CT, MRI, or nuclear imaging studies) for one week prior to BMD. **Weight limit is 330 lb for this exam.**

☐ **BODY COMPOSITION** (a charge will apply, call for more information)

ULTRASOUND (PREPARATION REQUIRED)

☐ **ABDOMEN** ☐ **ELASTOGRAPHY**

After midnight, nothing to eat or drink, no chewing gum or candies and no smoking. For infants, withhold the last feeding prior to the appointment time. Medication(s) can be taken with a small amount of water.

☐ **PELVIS** ☐ **KIDNEYS, URETER, AND BLADDER (KUB)**

FINISH drinking 4 glasses of water, 8 oz. each (1 L total), 90 minutes before the appointment time. DO NOT VOID. DO NOT SUBSTITUTE WITH ANY OTHER LIQUID. A full bladder is necessary to perform the exam. If the bladder is not full,the examination will be rescheduled. Children (12 and under) are only required to drink 2 glasses of water, 8 oz. each (500 mL total).

☐ **ABDOMEN AND PELVIS**

After midnight, nothing to eat, no chewing gum or candies and no smoking. FINISH drinking 4 glasses of water, 8 oz. each (1 L total), 90 minutes before the appointment time. DO NOT VOID. DO NOT SUBSTITUTE WITH ANY OTHER LIQUID. A full bladder is necessary to perform the exam. If the bladder is not full, the examination will be rescheduled. Children (12 and under) are only required to drink 2 glasses of water, 8 oz. each (500 mL total).

☐ **OBSTETRIC**

90 minutes prior to your appointment, empty your bladder, then drink water with 15 minutes as specified below. The amount of water you need to drink depends on how far along you are in your pregnancy:

- Up to 25 weeks - 3 glasses of water, 8 oz. each (750 mL total)
- Over 25 weeks - 1 glass of water, 8 oz. (250 mL total)

DO NOT VOID. DO NOT SUBSTITUTE WITH ANY OTHER LIQUID. A full bladder is necessary to perform the exam. If the bladder is not full, the examination will be rescheduled. DO NOT BRING CHILDREN TO YOUR APPOINTMENT, unless accompanied by an adult (other than the patient). Fathers with children present will be asked to remain in the waiting room until the end of the exam when they can be brought in to view the baby. Fathers unaccompanied by children are welcome to view the ultrasound.

☐ **ARTERIAL DOPPLER** *

☐ Upper extremities (No preparation)

☐ Lower extremities (Nothing to eat or drink after midnight)

☐ Renal arteries (Nothing to eat or drink after midnight)

***PLEASE FAX REQUISITION TO BOOK ARTERIAL EXAMS**

ULTRASOUND (NO PREPARATION REQUIRED)

☐ **ECHOCARDIOGRAM**

☐ PRIOR VALVE REPLACEMENT

TYPE:_____ ANNULAR SIZE:_____

☐ **ARM VENOUS DOPPLER** ☐ **LEG VENOUS DOPPLER**

☐ BILATERAL ☐ LEFT ☐ RIGHT

☐ **BREAST**

☐ BILATERAL ☐ LEFT ☐ RIGHT

☐ **CAROTID DOPPLER**

☐ **HERNIA**

☐ VENTRAL ☐ UMBILICAL ☐ INCISIONAL

☐ **INGUINAL HERNIA**

☐ BILATERAL ☐ LEFT ☐ RIGHT

☐ **MUSCULOSKELETAL**

ACHILLES	☐ LEFT	☐ RIGHT	☐ BILATERAL
ANKLE	☐ LEFT	☐ RIGHT	
ELBOW	☐ LEFT	☐ RIGHT	
FINGER	☐ LEFT	☐ RIGHT	SITE:_____
FOOT	☐ LEFT	☐ RIGHT	
HIP	☐ LEFT	☐ RIGHT	
KNEE	☐ LEFT	☐ RIGHT	
SHOULDERS	☐ LEFT	☐ RIGHT	☐ BILATERAL
SOFT TISSUE	SITE:_____		
WRIST	☐ LEFT	☐ RIGHT	

☐ **NECK**

☐ **PEDIATRIC HIPS** EDC: _____

☐ **SCROTUM**

☐ **THYROID**

☐ **VEIN MAPPING**

☐ **VEIN THERAPY CONSULT** (Requires a separate letter of request)

☐ **OTHER:**_____