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Please bring this FORM & a VALID OHIP CARD to your appointment:

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Test Preparation reverse side

**Kennedy Eglinton**

**X-Ray & Ultrasound (UXB)**

2374 Eglinton Ave. E, LL  
Scarborough, ON M1K 2P4  
T:416-757-8497 F:416-757-4146

**Lawrence Bathurst**

**X-Ray & Ultrasound (UXB)**

508 Lawrence Ave. W., #25B  
Toronto, ON M6A 1A1  
T:416-787-0229 F:416-787-0220

**Bloor Christie**

**X-Ray & Ultrasound (UXB)**

716 Bloor Street West  
Toronto, ON M6G 1L4  
T:416-588-5937 F:416-588-5094

**Finchgate X-Ray &**

**Ultrasound (UXBF)**

**FREE PARKING**

40 Finchgate Blvd., #320  
Bramalea, ON L6T 3J1  
T:905-792-8440 F:905-792-0806

**Heartlake X-Ray &**

**Ultrasound (UX)**

10425 Kennedy Rd N., #104  
Brampton, On L6Z 0A4  
T:905-846-7733 F: 905-846-5414

**Whitby Medical X-Ray**

**& Ultrasound (UXBV)**

220 Dundas St. W., #420  
Whitby, ON L1N 8M7  
T:905-430-1781 F: 905-430-1776

**Niagara Falls**

**X-Ray & Ultrasound (UXB)**

6453 Morrison St., Unit 1  
Niagara Falls, ON L2E 7H1  
T:905-374-1686 F:905-374-4950

X-RAY (X); Ultrasound (U); Bone Density (B); Vascular Ultrasound (V); Barium Studies (F)

\*Please arrive 10 minutes early for your appointment

\* If you have to cancel your appointment, please give at least 24 hours notice

Patient Full Name: \_\_\_\_\_ H.I.N.: \_\_\_\_\_ VC \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone #: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Gender:  M  F

**ULTRASOUND (by appointment)**

<p><b>ABDOMEN</b></p> <p><input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Abdomen + Pelvic</p> <p><input type="checkbox"/> Abdomen + Pelvic + Transvaginal</p> <p><input type="checkbox"/> Abdomen + Pelvic Limited</p> <p><input type="checkbox"/> Abdominal Wall</p> <p><input type="checkbox"/> AAA Screening</p> <p><input type="checkbox"/> KUB</p> <p><input type="checkbox"/> Renal</p> <p><input type="checkbox"/> Bladder</p>	<p><b>MUSCULOSKELETA</b></p> <p><b>L</b></p> <p>R L</p> <p><input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> Bicep</p> <p><input type="checkbox"/> Elbow</p> <p><input type="checkbox"/> Forearm</p> <p><input type="checkbox"/> Wrist</p> <p><input type="checkbox"/> Hand</p> <p><input type="checkbox"/> Hip</p> <p><input type="checkbox"/> Hand</p> <p><input type="checkbox"/> Knee</p> <p><input type="checkbox"/> Popliteal Fossa</p> <p><input type="checkbox"/> Achilles Tendon</p> <p><input type="checkbox"/> Ankle</p> <p><input type="checkbox"/> Foot</p> <p><input type="checkbox"/> Plantar Fascia</p>	<p><b>OBSTETRICAL</b></p> <p><b>LMP: DD/MM/YYYY</b></p> <p><input type="checkbox"/> Dating (&lt;16 weeks)</p> <p><input type="checkbox"/> Prenatal Screening (IPS/eFTS) 11-14 weeks</p> <p><input type="checkbox"/> Anatomic 18-20 weeks</p> <p><input type="checkbox"/> Biophysical Profile (BPP)</p> <p><input type="checkbox"/> Fetal Growth</p> <p><b>FEMALE PELVIS</b></p> <p><input type="checkbox"/> Pelvic</p> <p><input type="checkbox"/> Transvaginal</p> <p><input type="checkbox"/> Pelvic + Transvaginal</p> <p><input type="checkbox"/> Follicular Studies</p> <p><b>BREAST</b> <input type="radio"/> OR <input type="radio"/></p>	<p><b>MALE PELVIS</b></p> <p><input type="checkbox"/> Pelvic - Transabdominal</p> <p><input type="checkbox"/> Prostate &amp; Bladder</p> <p><input type="checkbox"/> Transrectal/ Prostate</p> <p><b>SMALL PARTS</b></p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Face</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Groin <input type="radio"/> OR <input type="radio"/></p> <p><input type="checkbox"/> Testes/Scrotum</p> <p><input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Soft Tissue/Lump</p>
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<b>VASCULAR (appointment)</b>	<b>BONE DENSITY (walk-in)</b>	<b>BARIUM STUDIES (appointment)</b>
<input type="checkbox"/> Carotid R L <input type="checkbox"/> Venous Upper Ext (DVT) <input type="checkbox"/> Venous Lower Ext (DVT) <input type="checkbox"/> Arterial Lower Ext (ABI) <input type="checkbox"/> Arterial Upper Ext	<input type="checkbox"/> Baseline Study (1 <sup>st</sup> Time) <input type="checkbox"/> Low Risk (Every 3-5 years) <input type="checkbox"/> High Risk (Every 12 months) <input type="checkbox"/> Date of Last BMD: _____	<input type="checkbox"/> Barium swallow <input type="checkbox"/> Upper G.I. series <input type="checkbox"/> U.G.I. & Small bowel

**X RAY (walk in)**

<p><b>CHEST</b></p> <p><input type="checkbox"/> Chest PA &amp; LAT</p> <p><input type="checkbox"/> Ribs <input type="radio"/> OR <input type="radio"/></p> <p><input type="checkbox"/> Sternum</p> <p><input type="checkbox"/> Chest (emigration)</p> <p><b>ABDOMEN</b></p> <p><input type="checkbox"/> Single View (KUB)</p> <p><input type="checkbox"/> Acute (3 views)</p> <p><b>SPINE &amp; PELVIS</b></p> <p><input type="checkbox"/> Cervical Spine</p> <p><input type="checkbox"/> Thoracic Spine</p> <p><input type="checkbox"/> Lumbo-Sacral Spine</p> <p><input type="checkbox"/> Sacrum &amp; Coccyx</p> <p><input type="checkbox"/> S.I. Joints</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> Scoliosis Series</p>	<p><b>UPPER EXTREMITIES</b></p> <p><b>R L</b></p> <p><input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> Clavicle</p> <p><input type="checkbox"/> A.C. Joints</p> <p><input type="checkbox"/> Scapula</p> <p><input type="checkbox"/> Humerus</p> <p><input type="checkbox"/> Elbow</p> <p><input type="checkbox"/> Forearm</p> <p><input type="checkbox"/> Wrist</p> <p><input type="checkbox"/> Scaphoid</p> <p><input type="checkbox"/> Hand</p> <p><input type="checkbox"/> Digits</p> <p>No. <input type="radio"/>1 <input type="radio"/>2 <input type="radio"/>3 <input type="radio"/>4 <input type="radio"/>5</p> <p><b>OTHER:</b> _____</p>	<p><b>LOWER EXTREMITIES</b></p> <p><b>R L</b></p> <p><input type="checkbox"/> Hip</p> <p><input type="checkbox"/> Femur</p> <p><input type="checkbox"/> Knee</p> <p><input type="checkbox"/> Tibia &amp; Fibula</p> <p><input type="checkbox"/> Ankle</p> <p><input type="checkbox"/> Foot</p> <p><input type="checkbox"/> Os Calcis</p> <p><input type="checkbox"/> Toes</p> <p>No. <input type="radio"/>1 <input type="radio"/>2 <input type="radio"/>3 <input type="radio"/>4 <input type="radio"/>5</p>	<p><b>HEAD &amp; NECK</b></p> <p><input type="checkbox"/> Skull</p> <p><input type="checkbox"/> Sinuses</p> <p><input type="checkbox"/> Adenoids</p> <p><input type="checkbox"/> Facial Bones</p> <p><input type="checkbox"/> Nasal Bones</p> <p><input type="checkbox"/> Mandible</p> <p><input type="checkbox"/> T.M. Joints</p> <p><input type="checkbox"/> Orbits</p> <p><input type="checkbox"/> Mastoids</p> <p><b>SKELETAL SURVEY</b></p> <p><input type="checkbox"/> Metastatic</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Bone Age</p>
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**CLINICAL INFORMATION**

NOT PREGNANT  STAT/VERBAL Tel: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_  
Physician's Name (print): \_\_\_\_\_  
Physician's Billing #: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
cc Physicians: \_\_\_\_\_  
Date (DD/MM/YYYY): \_\_\_\_\_  
Report Delivery:  Fax  HRM  Other