



Burlington Professional Centre  
 3155 Harvester Rd., Suite 310  
 Burlington, ON L7N 3V2  
 Tel: (905) 637-6608  
 Fax: (905) 637-1155  
 www.stlimaging.ca

|                  |      |
|------------------|------|
| APPOINTMENT DATE | TIME |
|------------------|------|

| <b>PATIENT INFORMATION</b> |                      |                                 |              |
|----------------------------|----------------------|---------------------------------|--------------|
| PATIENT'S LAST NAME        | PATIENT'S FIRST NAME |                                 | SEX<br>F   M |
| HEALTH NUMBER              | VERSION              | DATE OF BIRTH<br>DD   MM   YYYY |              |
| ADDRESS                    |                      | PHONE NO.                       |              |

| <b>X-RAY</b>  | <b>ULTRASOUND</b> (For preparation see over)   |
|---|--|
| <input type="checkbox"/> CHEST<br><input type="checkbox"/> RIBS <span style="float: right;">L R</span><br><br><input type="checkbox"/> CERVICAL SPINE<br><input type="checkbox"/> THORACIC SPINE<br><input type="checkbox"/> LUMBAR SPINE<br><input type="checkbox"/> SACRUM / COCCYX<br><input type="checkbox"/> SI JOINTS<br><input type="checkbox"/> PELVIS & HIPS <span style="float: right;">L R</span><br><br><input type="checkbox"/> ABDOMEN-VIEWS 1 <input type="checkbox"/> 3 <input type="checkbox"/><br><input type="checkbox"/> SKULL<br><input type="checkbox"/> FACIAL BONES<br><input type="checkbox"/> NASAL BONES<br><input type="checkbox"/> ORBITS<br><input type="checkbox"/> MANDIBLE<br><br><input type="checkbox"/> CLAVICLE<br><input type="checkbox"/> SCAPULA<br><input type="checkbox"/> SHOULDER<br><input type="checkbox"/> AC JOINTS<br><input type="checkbox"/> HUMERUS<br><input type="checkbox"/> ELBOW<br><input type="checkbox"/> FOREARM<br><input type="checkbox"/> WRIST<br><input type="checkbox"/> HAND<br><input type="checkbox"/> _____ FINGERS<br><input type="checkbox"/> FEMUR<br><input type="checkbox"/> KNEE<br><input type="checkbox"/> TIB-FIB<br><input type="checkbox"/> ANKLE<br><input type="checkbox"/> FOOT<br><input type="checkbox"/> _____ TOE<br><br><input type="checkbox"/> OTHER _____<br>_____ | <input type="checkbox"/> ABDOMEN<br><input type="checkbox"/> PELVIS<br><input type="checkbox"/> TRANSVAGINAL<br><input type="checkbox"/> TRANSRECTAL<br><input type="checkbox"/> SCROTUM<br><input type="checkbox"/> GROIN (Hernia)<br><input type="checkbox"/> THYROID<br><input type="checkbox"/> NECK<br><input type="checkbox"/> SALIVARY GLAND<br>Site _____<br><input type="checkbox"/> BREAST <span style="float: right;">L R</span><br><b>DOPPLER</b><br><input type="checkbox"/> CAROTID<br><input type="checkbox"/> PERIPHERAL VENOUS LEGS <span style="float: right;">L R</span><br><input type="checkbox"/> PERIPHERAL VENOUS ARMS <span style="float: right;">L R</span><br><input type="checkbox"/> PERIPHERAL ARTERIAL LEGS <span style="float: right;">L R</span><br><input type="checkbox"/> OTHER _____<br><br><b>MUSKULOSKELETAL</b><br><input type="checkbox"/> SHOULDER <span style="float: right;">L R</span><br><input type="checkbox"/> KNEE <span style="float: right;">L R</span><br><input type="checkbox"/> WRIST <span style="float: right;">L R</span><br><input type="checkbox"/> ELBOW <span style="float: right;">L R</span><br><input type="checkbox"/> ANKLE <span style="float: right;">L R</span><br><input type="checkbox"/> HAND <span style="float: right;">L R</span><br><input type="checkbox"/> LUMP / MASS<br>SITE _____<br><br><b>OBSTETRICAL</b><br><input type="checkbox"/> NUCHAL TRANSLUCENCY (eFTS)<br><input type="checkbox"/> 1ST TRIMESTER (Dating)<br><input type="checkbox"/> ANATOMICAL SURVEY<br><input type="checkbox"/> 3RD TRIMESTER |

**\* CLINICAL INFORMATION \*** **THIS SECTION MUST BE COMPLETED IN FULL BEFORE EXAMINATION.**

REASON FOR EXAMINATION (RELEVANT HISTORY):

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|   |           |
|---|-----------|
| REQUISITIONING MEDICAL PRACTITIONER / RNEC & OHIP NO. | PHONE NO. |
|---|-----------|

|                                |      |     |    |      |
|--------------------------------|------|-----|----|------|
| PHYSICIAN'S / RNEC'S SIGNATURE | DATE | DAY | MO | YEAR |
| <b>X</b>                       |      |     |    |      |

# ULTRASOUND PREPARATION

## ABDOMEN

- Nothing to eat or drink after midnight.
- No breakfast.
- Take usual medication with small amount of water.

## ABDOMEN AND PELVIS

- Nothing to eat or drink after midnight.
- A full bladder is required.
- Drink 4 regular glasses of water (32 oz. or 1 litre) to be finished one hour before the examination.
- Do not void until after the ultrasound.
- Take usual medication with water.

## PELVIS, OBSTETRICAL AND PROSTATE

- A full bladder is required.
- Drink 4 regular glasses of water (32 oz. or 1 litre) to be finished one hour before the examination.
- Do not void until after the ultrasound.
- May include a transvaginal exam as required.

## TRANSRECTAL

- Fleet enema is required 2 hours prior to appointment.

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