

PATIENT INFORMATION:

PATIENT'S NAME: _____ D.O.B: _____ F M

ADDRESS: _____

TELEPHONE #: _____ OHIP #: _____

APPOINTMENT DATE: _____ TIME: _____ LMP: _____ WEIGHT: _____

*Note: Please see back for patient instructions and directions WSIB Check if applicable **STAT**

ULTRASOUND

By Appointment - Wharncliffe | Waterloo | Southdale

<input type="checkbox"/> Follicular Studies (Transvaginal) <input type="checkbox"/> OB U/S for dating (<i>less than 16 weeks</i>) <input type="checkbox"/> OB U/S ROUTINE (<i>18 - 20 weeks</i>) <input type="checkbox"/> OB U/S NON-ROUTINE Complications or high risk: _____ <input type="checkbox"/> IPS (<i>between 11 to 13 weeks</i>) <i>(please bring all IPS paper work)</i> <input type="checkbox"/> Full Abdomen (<i>includes limited pelvic screen</i>) <i>(no pelvic prep required)</i> <input type="checkbox"/> Upper Abdomen Only (<i>no pelvic screen</i>) <input type="checkbox"/> Aorta Only <input type="checkbox"/> Pelvic <input type="checkbox"/> Renal <input type="checkbox"/> Prostate / Transrectal <input type="checkbox"/> Thyroid <input type="checkbox"/> Soft Tissue Neck / Abdominal Wall <input type="checkbox"/> Other: _____	MSK R L <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Popliteal Fossa <input type="checkbox"/> Ankle <input type="checkbox"/> Achille
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Kidney Only
 Proceed to transvaginal, if appropriate
 Bladder
 Scrotal / Testicular
 Salivary Gland

X-RAY

No Appointment - Wharncliffe | Waterloo | Southdale

HEAD & NECK <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> Orbits <input type="checkbox"/> TMJ - Temporomandibular Jt	SPINE & PELVIS <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar (L/S) Spine <input type="checkbox"/> Sacrum / Coccyx <input type="checkbox"/> S.I. Joints <input type="checkbox"/> Pelvis <input type="checkbox"/> Scoliosis Series	UPPER EXTREMITIES R L <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus <input type="checkbox"/> Clavicle <input type="checkbox"/> A.C. Joints <input type="checkbox"/> Scapula <input type="checkbox"/> Wrist <input type="checkbox"/> Scaphoid <input type="checkbox"/> Hand & Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger: 1 2 3 4 5 <input type="checkbox"/> Bone Age
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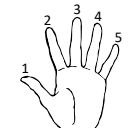
CHEST
 Chest PA & LAT
 Ribs R L B
(includes PA Chest)
 Sternoclavicular Joints
 Sternum
 Other: _____

LOWER EXTREMITIES
R L
 Hip (*under 40 only*)
 Pelvis & Hip
 Femur
 Knee
 Tib. & Fib.
 Ankle
 Foot
 Calcaneus
 Toe: 1 2 3 4 5

ABDOMEN
 Single / KUB
 Acute (*includes PA chest*)

OTHER X-RAY: _____

GASTRICS (By Appointment - Wharncliffe Rd. N.)
 Upper GI Barium Swallow Small Bowel Barium Enema



VASCULAR DOPPLER

By Appointment - Wharncliffe | Waterloo

<input type="checkbox"/> Carotid <input type="checkbox"/> Venous - Lower Extremity (DVT) <input type="checkbox"/> Venous - Lower Extremity (Reflux) <input type="checkbox"/> Venous - Upper Extremity (DVT) <input type="checkbox"/> Arterial - Lower Extremity (with ABI) <input type="checkbox"/> Arterial - Upper Extremity	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> B <input type="checkbox"/> B
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BONE MINERAL DENSITY

By Appointment - Wharncliffe

Baseline Study High Risk BMD (every 12 months) Low Risk BMD

1. Has your patient had a fragility fracture after age 40? Yes No
2. Is your patient on prolonged course of corticosteroid treatment of longer than 3 months? Yes No

*Please provide us with most recent BMD report if exam was not done at one of our clinics.
 MOH restricts Low Risk exams to one follow-up at 36 months and subsequent follow-ups at 60 months.*

CARDIOLOGY

HOLTER MONITORING Wharncliffe | *Arva
 24 hrs 48 hrs 72 hrs ___ hrs 2 wks

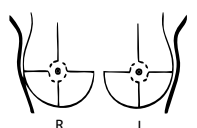
21589 Richmond St. Arva Clinic Only

12-LEAD ELECTROCARDIOGRAM (ECG)
 ECHOCARDIOGRAM (COLOUR DOPPLER)
Please select one of the following indications:
 Chest pain suspicious of CAD Palpitations / arrhythmias Hypertension
 Congestive heart failure Murmur Syncope
 Other: _____

***By appointment - 21589 Richmond St., Arva (519-672-0070)**
Please see MyHealth Centre cardiology requisition for all procedures performed at our Arva location.

MAMMOGRAPHY & BREAST ULTRASOUND

By Appointment - Wharncliffe

<input type="checkbox"/> Mammogram <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> Implants <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <input type="checkbox"/> OBSP (Ontario Breast Screening Program)	
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ELECTROMYOGRAPHY CONSULTATION

EMG CONSULTATION / NERVE CONDUCTION STUDY (By Appointment - Wharncliffe)

Clinical Information: _____

Referring Physician: _____ Print Name _____ Signature _____ Fax #: _____

Copy To: _____ Print Name _____ Fax #: _____

PATIENT PREPARATION AND INSTRUCTIONS

NOTES:

1. A valid health card must be shown at every visit.
2. A signed requisition by a registered physician is mandatory for all exams.
3. If you would like to cancel/change your appointment, please notify our office at least 24 hours prior to your scheduled time.
4. Please bring toonies/loonies for paid parking at 279 Wharncliffe Rd. N. location.

For additional locations across Ontario, visit www.myhealthcentre.ca

ULTRASOUND

ABDOMEN

No eating or drinking (smoking or chewing gum) 8 hours prior to appointment.

ABDOMEN / PELVIC

No eating or drinking 8 hours prior to appointment EXCEPT that you must drink 34 oz or 1 litre of water FINISHED 1 hour prior to appointment.

START AT: _____ FINISH BY: _____

Do not empty bladder before examination.

OBSTETRICAL / PELVIC

Drink 34 oz or 1 litre of water 1 hour prior to appointment.

START AT: _____ FINISH BY: _____

Do not empty bladder before examination.

PROSTATE (TRANSRECTAL)

Fleet enema 2 hours before the examination (kit may be purchased at your pharmacy). Drink 34 oz or 1 litre of water FINISHED 1 hour prior to appointment.

Do not empty bladder before examination.

MAMMOGRAM

Do not wear any deodorant, powder and perfume prior to appointment.
Wear a separate blouse with skirt or slacks.

GASTRICS

STOMACH, UGI, BARIUM SWALLOW, SMALL BOWEL

Nothing to eat or drink after midnight, which includes chewing gum, candies and smoking.

For Small Bowel, please allow 1 to 2 hours for appointment.

COLON EXAMINATION (BARIUM ENEMA)

Purchase Golytely or Colyte Kit at your pharmacy 2 days prior to your appointment. Preparation must be taken the day before your examination.

Follow instructions provided with kit. Clear fluids such as tea, coffee, broth, jello, soft drinks, fruit juices only for 2 days before examination. **No milk or solid foods.**

BONE MINERAL DENSITY (BMD)

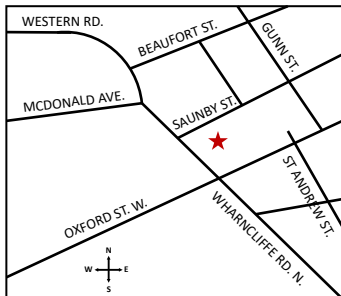
Do not take calcium/vitamin supplements 24 hours prior to exam.

Patients are asked to wear clothing without zippers or metal attachments.

If you have had a nuclear medicine dye injection or a barium study within 2 weeks, please reschedule your BMD test.

Weight limit ≤ 300 lb Age limit ≥ 20 years

PLEASE DO NOT WEAR ANY SCENTED PRODUCTS



279 Wharncliffe Road North, Suite 111
London, ON N6H 2C2
Tel: 519-661-0275 | Fax: 519-661-0616

HOURS OF OPERATION:

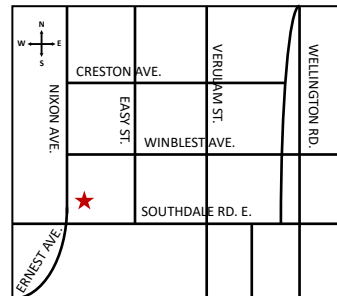
Mon., Tues. & Thurs. 7:30am-5:30pm
Wed. 7:30am-7:00pm
Fri. 7:30am-5:00pm
Sat. 8:00am-12:00pm



111 Waterloo Street, Suite 100
London, ON N6B 2M5
Tel: 519-432-3715 | Fax: 519-432-1980

HOURS OF OPERATION:

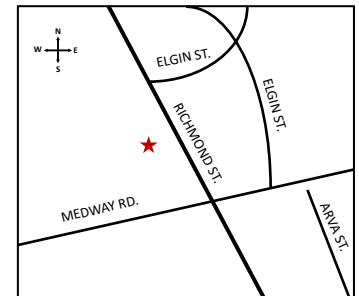
Mon.-Fri. 8:00am-5:00pm



510 Southdale Road East, Suite 103
London, ON N6E 0B2
Tel: 226-663-2933 | Fax: 226-663-4561

HOURS OF OPERATION:

Mon.-Fri. 9:00am-5:00pm



21589 Richmond Street
Arva, ON NOM 1C0
Tel: 519-672-0070 | Fax: 519-850-0144

HOURS OF OPERATION:

Call 519-672-0070