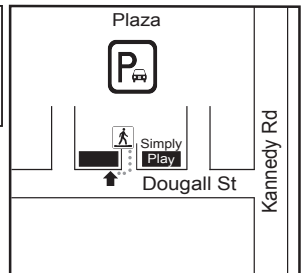




CALEDON MEDICAL IMAGING

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REQUEST FOR ASSESSMENT WE ACCEPT WALK-IN PATIENTS

PATIENTS NAME:	OHIP #:
TEL #:	D.O.B:
INDICATION:	
REFERRING PHYSICIAN:	DATE:
PHYSICIAN BILLING#:	TEL #:

General Ultrasound

- Abdomen
- Abdomen Limited
- Abdomen & Pelvis
- K.U.B.
- PTV (unless contraindicated)
- Pelvis M F TV
- Prostate
- Scrotum
- Thyroid
- Chest Mass Axillary
- Breast R L
- Neck
- Soft tissue/ lump
- Other _____

Obstetrical

- 1st Trimester*
- Dating LMP DD / MM / YY
 - Nuchal translucency (11w-13w 6 days)
 - Other _____
- 2nd Trimester*
- Anatomy (18-20 weeks)
 - Twin Anatomy (18-20 weeks)
 - Other _____
- 3rd Trimester*
- BPP BPP with growth
 - Other _____

Musculoskeletal (only bilateral are scheduled)

- | | |
|--|--|
| R L | R L |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Quadriceps |
| <input type="checkbox"/> A.C. Joint | <input type="checkbox"/> Hamstring |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Wrist & Hand | <input type="checkbox"/> Calves |
| <input type="checkbox"/> Wrist (Carpal Tunnel) | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Abdominal Wall (Hernia) | <input type="checkbox"/> Achilles tendon |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Foot |
| | <input type="checkbox"/> Plantar Fascia |
| | <input type="checkbox"/> Other _____ |

VASCULAR

PERIPHERAL ARTERIAL

- Carotids
- Lower Extremity (Incl. Aorta, ABI, TBI) R L
- Upper Extremity R L
- Other _____

PERIPHERAL VENOUS

- Lower Extremity R L
- Upper Extremity R L
- Rule out DVT R L
- Other _____

PATIENT PREPARATIONS AND INSTRUCTIONS ON REVERSE SIDE.
 PHYSICIANS PLEASE CHECK APPROPRIATE BOX INDICATING PATIENT PREPARATION INSTRUCTIONS