RadiologyAssociates

EMERGENT CARE REQUISITION

radiologyassociatesinc.com

Booking Information

Phone: 403-328-1122 Fax: 403-328-1218

☐ 1122 Scenic Dr S, Lethbridge, AB T1K 7E5

☐ 65 Columbia Blvd W, Lethbridge, AB T1K 4B7

☐ U3T MRI at U of L

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)

ADDRESS: CITY:

POSTAL CODE: PROVINCE:

PHONE #: HOME WORK / CELL

☐ AHC#: ☐ WCB#:

☐ OUT OF PROVINCE#:

AGE: DOB: (MM / DD / YEAR) LMP: (MM / DD / YEAR)

☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ NO

REFERRAL

ORDERING PHYSICIAN:

ORDERING EMERG DEPARTMENT:

FAX REPORTS TO #:

SEND COPY TO:

CLINIC NAME:

FAX REPORTS TO #:

MUST SPECIFY URGENCY

☐ 1 - NEXT DAY
☐ 2 - WITHIN ONE WEEK
☐ 3 - WITHIN TWO WEEKS
☐ 4 - ROUTINE BOOKING

HISTORY & PROVISIONAL DIAGNOSIS:

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

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

_____ M.D.

EXAM

ULTRASOUND (PREPARATION REQUIRED)

☐ ABDOMEN ☐ ELASTOGRAPHY

After midnight, nothing to eat or drink, no chewing gum or candies and nosmoking. 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 with15 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 PREPARATIONREQUIRED)

☐ **ECHOCARDIOGRAM**
☐ PRIOR VALVE REPLACEMENT
TYPE:_____ ANNULAR SIZE:_____

☐ **ARM VENOUS DOPPLER**
☐ BILATERAL ☐ LEFT ☐ RIGHT

BREAST ☐ BILATERAL ☐ LEFT ☐ RIGHT

☐ **CAROTID DOPPLER**

☐ **HERNIA** ☐ VENTRAL ☐ UMBILICAL ☐ INCISIONAL

☐ **INGUINALHERNIA**
☐ BILATERAL ☐ LEFT ☐ RIGHT

☐ **LEG VENOUS DOPPLER**
☐ 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:**_____