

PATIENT	APPOINTMENT DATE / TIME: _____	<b>BRING VALID HEALTH CARE CARD &amp; THIS FORM.</b> If you are unable to attend your appointment, please call to cancel or reschedule at least 2 hours prior to your appointment. <b>NO SHOWS MAY BE CHARGED. CHILDREN ARE NOT ALLOWED IN EXAM ROOMS. CHILD CARE IS NOT PROVIDED</b>
	NAME: _____ (LAST) (FIRST) (MIDDLE)	<input type="checkbox"/> AHC#: _____ <input type="checkbox"/> WCB#: _____
ADDRESS: _____ CITY: _____	<input type="checkbox"/> OUT OF PROVINCE#: _____	
POSTAL CODE: _____ PROVINCE: _____	AGE: _____ DOB: _____ (MM / DD / YEAR) LMP: _____ (MM / DD / YEAR)	
PHONE #: _____ HOME _____ WORK / CELL _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO	

REFERRAL	ORDERING PHYSICIAN: _____	SEND COPY TO: _____
	ORDERING PRAC ID: _____	CLINIC NAME: _____
	CLINIC NAME: _____	PHONE #: _____
	PHONE #: _____ FAX #: _____	FAX REPORTS TO #: _____

**HISTORY & PROVISIONAL DIAGNOSIS:**

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

Relevant prior imaging: \_\_\_\_\_ M.D.

(LOCATION AND DATE OF EXAM)

EXAM	<input type="checkbox"/> <b>MAMMOGRAPHY</b>	<input type="checkbox"/> <b>X-RAY</b>	<input type="checkbox"/> <b>BONE DENSITOMETRY</b>
	<input type="checkbox"/> IMPLANTS (requires more time) <input type="checkbox"/> PREVIOUS BREAST CANCER On the day of the exam, wash off all deodorants, perfumes, powders and/or lotions under the arm and across the chest.	<b>(No preparation required)</b> BODY PART: _____	Bring a list of all prescribed medications and amount of calcium and vitamin D in supplement form. No metal (including zippers and underwire bras) from the armpit down to just above the knees. If possible, remove bellybutton ring. No contrast exams (e.g., barium, CT, MRI, or nuclear imaging studies) for one week prior to BMD. Weight limit is 330 lb for this exam.

EXAM	<b>ULTRASOUND (PREPARATION REQUIRED)</b>	<b>ULTRASOUND ( NO PREPARATION REQUIRED)</b>																																				
	<input type="checkbox"/> <b>ABDOMEN</b> <input type="checkbox"/> <b>ELASTOGRAPHY</b> <input type="checkbox"/> <b>APPENDIX (FULL BLADDER REQUIRED)</b> After midnight, nothing to eat or drink, no chewing gum or candies and no smoking. For infants, withhold the last feeding prior to the appointment time. Medication(s) can be taken with a small amount of water.	<input type="checkbox"/> <b>ECHOCARDIOGRAM</b> <input type="checkbox"/> PRIOR VALVE REPLACEMENT? HT: _____ WT: _____ PROVIDE ALL PRIOR REPORTS																																				
	<input type="checkbox"/> <b>PELVIS AND KIDNEYS</b> <input type="checkbox"/> <b>KIDNEYS, URETER &amp; BLADDER (KUB)</b> <input type="checkbox"/> <b>APPENDIX</b> 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).	<input type="checkbox"/> <b>ARM VENOUS DOPPLER</b> <input type="checkbox"/> <b>LEG VENOUS DOPPLER</b> <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT																																				
	<input type="checkbox"/> <b>ABDOMEN AND PELVIS</b> 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).	<input type="checkbox"/> <b>BREAST</b> <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT																																				
	<input type="checkbox"/> <b>OBSTETRIC</b> 90 minutes prior to your appointment, empty your bladder, then drink water with 15 minutes as specified below. The amount of water you need to drink depends on how far along you are in your pregnancy:	<input type="checkbox"/> <b>CAROTID DOPPLER</b> <input type="checkbox"/> <b>HERNIA</b> <input type="checkbox"/> VENTRAL <input type="checkbox"/> UMBILICAL <input type="checkbox"/> INCISIONAL																																				
	<ul style="list-style-type: none"> <li>Up to 25 weeks - 3 glasses of water, 8 oz. each (750 mL total)</li> <li>Over 25 weeks - 1 glass of water, 8 oz. (250 mL total)</li> </ul> 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.	<input type="checkbox"/> <b>INGUINAL HERNIA</b> <input type="checkbox"/> BILATERAL <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT																																				
	<input type="checkbox"/> <b>ARTERIAL DOPPLER *</b> <input type="checkbox"/> Upper extremities (No preparation) <input type="checkbox"/> Lower extremities <input type="checkbox"/> Renal arteries After midnight, nothing to eat. FINISH drinking 4 glasses of water, 8 oz. each (1 L total), 90 minutes before the appointment time. Void when necessary. *PLEASE FAX REQUISITION TO BOOK ARTERIAL EXAMS	<input type="checkbox"/> <b>MUSCULOSKELETAL</b> <table border="0"> <tr><td>ACHILLES</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td><input type="checkbox"/> BILATERAL</td></tr> <tr><td>ANKLE</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td></td></tr> <tr><td>ELBOW</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td></td></tr> <tr><td>FINGER</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td>SITE: _____</td></tr> <tr><td>FOOT</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td></td></tr> <tr><td>HIP</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td></td></tr> <tr><td>KNEE</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td></td></tr> <tr><td>SHOULDERS</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td><input type="checkbox"/> BILATERAL</td></tr> <tr><td>WRIST</td><td><input type="checkbox"/> LEFT</td><td><input type="checkbox"/> RIGHT</td><td></td></tr> </table>	ACHILLES	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT	<input type="checkbox"/> BILATERAL	ANKLE	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT		ELBOW	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT		FINGER	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT	SITE: _____	FOOT	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT		HIP	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT		KNEE	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT		SHOULDERS	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT	<input type="checkbox"/> BILATERAL	WRIST	<input type="checkbox"/> LEFT	<input type="checkbox"/> RIGHT	
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		<input type="checkbox"/> <b>NECK</b> <input type="checkbox"/> <b>PEDIATRIC HIPS</b> EDC: _____ <input type="checkbox"/> <b>SCROTUM</b> <input type="checkbox"/> <b>THYROID</b> <input type="checkbox"/> <b>VEIN MAPPING</b> <input type="checkbox"/> <b>VEIN THERAPY CONSULT</b> (Requires a separate letter of request) <input type="checkbox"/> <b>OTHER:</b> _____																																				