Campbellford Memorial Hospital

DIAGNOSTIC IMAGING
FAX requisition to (705) 653-3601
Incomplete Requisitions will be returned

☐ OUT-PATIENT ☐ URGENT ☐ ELECTIVE ☐ INPATIENT ☐ ISOLATION TYPE:_____

PATIENT INFORMATION (Please Print)

Last Name _____

First Name _____

Address_____

City_____ Postal Code_____

Phone Home#_____Cell#_____

DOB D___M___Y___

Health Card No._____

PHYSICIAN INFORMATION (Please Print)

Physician Name_____

Phone_____ Billing No._____

Fax _____

Copies to:_____

_____

RADIOGRAPHY

Examination(s) requested:_____

History:

_____ _____
Date Physician's Signature

ULTRASOUND

Examination(s) requested: _____

Vascular Ultrasound

☐ **Carotid Doppler** ☐ **Arterial Doppler** ☐ **Arm** ☐ **Leg** ☐ **Right** ☐ **Left**

☐ **Venous Doppler** ☐ **Arm** ☐ **Leg** ☐ **Right** ☐ **Left**

History:

_____ _____
Date Physician's Signature

BREAST STUDIES **Routine Screening** ☐ **Ontario Breast Screening** ☐

Previous Mammogram? ☐ **Yes** ☐ **No**

Breast Implants? ☐ **Yes** ☐ **No**

History:

_____ _____
Date Physician's Signature

BONE MINERAL DENSITY (BMD) ☐

Previous BMD? Yes ☐ No ☐ Location Date

Please Fax prior report if not completed at CMH. The information below must be completed for a bone mineral density request.

History: Risk: Low ☐ High ☐ Risk Factors:

Treatment: None ☐ Calcium ☐ Vit D ☐ Bisphosphonate ☐
Prolia ☐ Forteo ☐ Evista ☐

_____ _____
Date Physician's Signature

↑ ALL OF THE ABOVE MUST BE COMPLETED IN FULL & SIGNED BY THE PHYSICIAN ↑

FOR THE PATIENT ⇨

1. **If you think you might be pregnant, please inform the radiology technologist.**
2. **Please see over for instructions. Your doctor will check the appropriate box.**
3. **Your personal health information will be disclosed only to care providers involved in your personal care unless you have expressly withheld or withdrawn your consent to do so.**

PATIENT INSTRUCTIONS

ULTRASOUND

☐ **Abdominal:** No eating or drinking for at least 6 hours prior to study. (Medications are allowed with small sips of water). Diabetic patients should advise booking clerk at time of appointment and diagnostic staff on arrival at the department.

☐ **Abdominal and Pelvis Ultrasound:** No food 6 hours prior. Drink 5 full glasses (40oz) of water one hour prior to appointment time **DO NOT VOID UNTIL INSTRUCTED**.

☐ **Pelvic & Early OBS Ultrasound:**

Finish 5 full glasses (40oz) of water one hour prior to appointment time. **DO NOT VOID UNTIL INSTRUCTED**.

☐ **G.U., KUB Ultrasound:** Finish 3 full glasses (24oz) of water one hour prior to study. **DO NOT VOID UNTIL INSTRUCTED**.

☐ **Late OBS Ultrasound (after 4th month):** Finish 2 full glasses (16oz) of water one hour prior to study.

☐ **All Others:** No preparation required.

BREAST STUDIES

☐ Do not use deodorant, talcum powder or any other ointment or cream on your breasts or underarms before your exam. Dress comfortably, preferably in a two piece outfit since you will be asked to undress above the waist for the procedure

BONE MINERAL DENSITY

☐ Cannot be done within one week of any Barium test (Upper GI, Barium Enema) or any Nuclear Medicine test.

Bring a list of medications. Wear clothing preferably without metal (e.g. no buttons, zippers, snaps), otherwise you will have to change into a hospital gown for your test.

OTHER

- If you require heart medications, you should take these as per your normal routine, using very small sips of water.
- Clear fluids include apple juice, clear jellies, consommé, water and tea. They do not include milk, coffee or orange juice.
- If you require insulin injections, you should discuss this with your doctor prior to coming for your test. Please inform the technologist.