



Toll Free Tel: 1-800-268-5804
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 www.stlimaging.ca

FACILITY (NO ABBREVIATIONS)		CITY / TOWN		PHONE NUMBER							
UNIT			ROOM #								
PATIENT'S LAST NAME			PATIENT'S FIRST NAME		SEX F M						
HEALTH NUMBER			VERSION CODE	DATE OF BIRTH DD MM YY							
MOBILE X-RAY			MOBILE ULTRASOUND (For preparation see over)								
<input type="checkbox"/> CHEST <input type="checkbox"/> RIBS L R <input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBER SPINE <input type="checkbox"/> SACRUM / COCCYX <input type="checkbox"/> SI JOINTS <input type="checkbox"/> PELVIS & HIPS L R <input type="checkbox"/> ABDOMEN-VIEWS 1 <input type="checkbox"/> 3 <input type="checkbox"/> <input type="checkbox"/> SKULL <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> NASAL BONES <input type="checkbox"/> ORBITS <input type="checkbox"/> MANDIBLE			<input type="checkbox"/> CLAVICLE <input type="checkbox"/> SHOULDER <input type="checkbox"/> AC JOINTS <input type="checkbox"/> HUMERUS <input type="checkbox"/> ELBOW <input type="checkbox"/> FOREARM <input type="checkbox"/> WRIST <input type="checkbox"/> HAND <input type="checkbox"/> _____ FINGERS <input type="checkbox"/> FEMUR <input type="checkbox"/> KNEE <input type="checkbox"/> TIB-FIB <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> _____ TOE <input type="checkbox"/> OTHER _____			<input type="checkbox"/> ABDOMEN <input type="checkbox"/> PELVIS <input type="checkbox"/> SCROTUM <input type="checkbox"/> GROIN (Hernia) <input type="checkbox"/> THYROID <input type="checkbox"/> NECK <input type="checkbox"/> SALIVARY GLAND Site _____ <input type="checkbox"/> BREAST L R <input type="checkbox"/> OTHER _____ _____			DOPPLER <input type="checkbox"/> VENOUS ARMS L R <input type="checkbox"/> VENOUS LEGS L R <input type="checkbox"/> ARTERIAL LEGS L R <input type="checkbox"/> ARTERIAL ARMS L R <input type="checkbox"/> CAROTID L R <input type="checkbox"/> LUMP / MASS Site _____		
<p>* CLINICAL INFORMATION * <i>THIS SECTION MUST BE COMPLETED IN FULL BEFORE EXAMINATION.</i></p> <p>REASON FOR EXAMINATION (RELEVANT HISTORY):</p> 											
INFECTION PRECAUTIONS REQUIRED <input type="checkbox"/> YES <input type="checkbox"/> NO											
REQUISITIONING MEDICAL PRACTITIONER / RNEC & OHIP NO.				UNIT NO. & EXT.							
PHYSICIAN'S / RNEC'S SIGNATURE			DATE	DAY	MO						
X											
			YEAR								

Ultrasound Preparation

ABDOMEN

- MODIFIED DIET CONTAINING:
 - NO MEAT
 - NO FAT
 - NO DAIRY
- The day of the scheduled ultrasound until the ultrasound is completed.
- Clear fluids only to be served with meals
- Patients can take all medication as required

ABDOMEN & PELVIS

- Restricted Diet (see above) with addition of a full bladder.
- Patient will need to drink 32oz (approximately 1 litre) prior to the technologist's arrival.
- Technologist will call and advise of the time to have the patient start drinking. The patient should be instructed not to void until the exam is completed (understandably, at times this may be difficult)

ALL OTHER EXAMS

- No preparation is needed

Please note examinations requiring preparations may not all be completed prior to lunch. The directions provided will need to be followed for the duration of the scheduled appointment date.