

PATIENT/APPOINTMENT INFORMATION

Healthcare Card required for appointment

LOCATIONS - Scan the QR Code for directions

NAME _____ M F
 DOB _____ Insurance/WCB # _____
 Address _____ Appointment Info _____
 Phone _____ Date _____ Time _____



Leduc
 5201 50 Street
 Leduc, AB T9E 6T4
 P: 780-612-5134
 F: 780-612-0364
MON - FRIDAY: 8:00 - 4:30 PM



Camrose
 #1 - 6601 48 Ave
 Camrose, AB T4V 3G8
 P: 780-672-8220
 F: 780-672-8250
MON - FRIDAY: 8:30 - 4:30 PM



Wetaskiwin
 4919 50 Street
 Wetaskiwin, AB T9A 1J6
 P: 587-468-8344
 F: 587-468-0169
MON - FRIDAY: 8:00 - 4:30 PM

CLINICAL HISTORY

X-RAY EXAM REQUESTED

Location _____

ULTRASOUND See back for exam preparation/instructions

General	Obstetrics	Musculoskeletal*
<input type="checkbox"/> Abdomen	<input type="checkbox"/> (Early/NT/Detailed)	<input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Renal	<input type="checkbox"/> 1st Trimester	<input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Nuchal Translucency	<input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Hernia	<input type="checkbox"/> Routine (>18 wk)	<input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Scrotum	<input type="checkbox"/> 2nd Trimester OB	<input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Neck/Thyroid	<input type="checkbox"/> 3rd Trimester OB	<input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Soft Tissue	<input type="checkbox"/> Biophysical (BPP)	<input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L
		<input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L
Chest	Cardiovascular	<input type="checkbox"/> Proceed with therapeutic injection if appropriate
<input type="checkbox"/> Chest Wall	<input type="checkbox"/> Carotid	
<input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Venous <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Other Ultrasound _____
<input type="checkbox"/> Axilla <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Echocardiogram	

PAIN THERAPY / PROCEDURES*

Radiologist Consultation
 The most appropriate study/procedure will be arranged

Repeats No. Times

Spine	Musculoskeletal	Special Procedures
<input type="checkbox"/> Epidural Injection	<input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Prolotherapy <input type="checkbox"/> Barbotage
<input type="checkbox"/> SI Joint(s) <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Location: _____ <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Nerve Root Block <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Platelet Rich Plasma (private service)
Level: _____	<input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L	Location: _____ <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Facet(s) Cervical <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Aspiration +/- Injection
Thoracic <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L	Location: _____ <input type="checkbox"/> R <input type="checkbox"/> L
Lumbar <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Other Procedure Requested
Level: _____	<input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L	Location: _____ <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> MBB/RFA (facet(s) location above) _____	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Coccyx _____		

BREAST IMAGING

Complete Breast Assessment (Mammo and Breast US as applicable)

Screening Mammography (with Tomosynthesis)

Screening Breast Ultrasound
 R L Bilateral

Diagnostic Mammography (with Tomosynthesis)
 R L Bilateral

Diagnostic Breast Ultrasound
 R L Bilateral

US Guided Breast Biopsy

BONE DENSITOMETRY

Baseline

>2 yr follow-up

<2 yr follow-up (applicable risk factors required)

Body Composition (private service)

< 50 yrs (must have referral from AMA approved specialist)

Risk Factors

Monitored "bisphosphonate holiday"

Therapy with potential drug effect

Post Transplant

Hyperparathyroidism

Supraphysiologic prednisone > 12 months

NUCLEAR MEDICINE

Bone Scan (SPECT/ CT as needed)

Specify Applicable Area(s) _____

Renal Scan Diuretic

Hepatobiliary (HIDA) Scan

GASTROINTESTINAL

UGI (esophagus, stomach, duodenum)

Small Bowel Follow Through

MRI* (Private Service)

Exam: _____ R L

Screening

<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Aneurysm surgery or clip
<input type="checkbox"/> Inner ear transplant	<input type="checkbox"/> Coronary, heart valve surgery
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Eye/head metal foreign body*
<input type="checkbox"/> Over 450 lbs	<input type="checkbox"/> Welder, metal worker *
<input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> Endoscope (<1 year)
<input type="checkbox"/> Gunshot, metal fragment	<input type="checkbox"/> Pregnant (LMP _____)

PRACTITIONERS INFORMATION

Practitioners Name _____

Signature _____

Phone/Fax _____

Copy To _____

Stat Phone Report
 P: _____

Stat Fax Report
 F: _____

Send Patient with Images (CD Copy)

Technologist Use Only

Date _____

Tech _____

Images _____

Shield Y N LMP _____ Date: _____

Remarks _____

Exam: _____

Relevant Prior
 Yes No