LLOYDMINSTER
MEDICAL IMAGING

REQUISITION FORM

APPOINTMENTS
Call 780-875-4600

MON-FRI: 8:00-4:30 PM

LOCATIONS

Meridian
#201 5119 47th Street
Lloydminster AB
T9V 0G1
P: 780-875-4600
F: 780-875-4602

LMI West
4121 70 Avenue
Lloydminster AB
T9V 3L9
P: 780-875-4600
F: 780-875-4602

PATIENT/APPOINTMENT INFORMATION

Healthcare Card required for appointment

Name _____ ☐ M ☐ F

DOB _____ Insurance/WCB # _____

Address _____ Appointment Info _____

Phone _____ Date _____ Time _____

CLINICAL HISTORY

Technologist Use Only

Date _____

Tech _____ # Images _____

Shield ☐ Y ☐ N LMP _____

Remarks _____

X-RAY EXAM REQUESTED

Location

ULTRASOUND

See back for exam preparation/instructions * Preliminary imaging performed when required

General
- ☐ Abdomen
- ☐ Renal
- ☐ Pelvis
- ☐ Groin
- ☐ Scrotum
- ☐ Neck
- ☐ Thyroid
- ☐ Soft Tissue

Obstetrics
- ☐ (Early/NT/Detailed)
- ☐ 1st Trimester
- ☐ Nuchal Translucency
- ☐ Routine (>18 wk)
- ☐ 2nd Trimester OB
- ☐ 3rd Trimester OB
- ☐ Biophysical (BPP)

Cardiovascular
- ☐ Echocardiogram
- ☐ Carotid
- ☐ DVT ☐ R ☐ L

Chest
- ☐ Breast ☐ R ☐ L
- ☐ Axilla ☐ R ☐ L
- ☐ Chest Wall

Musculoskeletal*
- ☐ Shoulder ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Ankle ☐ R ☐ L
- ☐ Other

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

MRI** (Private Service)

Exam: _____

☐ R ☐ L

NUCLEAR MEDICINE**

- ☐ Bone Scan (SPECT/CT as needed)

_____
Specify Applicable Area(s)

- ☐ Renal Scan ☐ Diuretic
- ☐ Hepatobiliary (HIDA) Scan

PAIN THERAPY

Preliminary imaging performed when required

☐ **Radiologist Consultation**
The most appropriate study/procedure will be arranged

Spine
- ☐ Epidural Injection
- ☐ Nerve Root Block ☐ R ☐ L
- ☐ SI Joint(s) ☐ R ☐ L
- ☐ Facet(s) ☐ R ☐ L

Level(s): _____

Musculoskeletal
- ☐ Shoulder ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Hand ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Knee ☐ R ☐ L
- ☐ Ankle ☐ R ☐ L
- ☐ Foot ☐ R ☐ L
- ☐ Other

Repeats

No. of Times _____ MD Initials _____

☐ Platelet Rich Plasma Assessment

PRACTITIONERS INFORMATION

** Services Performed at our Leduc Location

Practitioners Name _____

Signature _____

Phone/Fax _____

Copy To _____

☐ Stat Phone Report
P: _____

☐ Stat Fax Report
F: _____

☐ Send Patient with Images (CD Copy)

PRACTITIONERS STAMP/ID

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