

PATIENT/APPOINTMENT INFORMATION

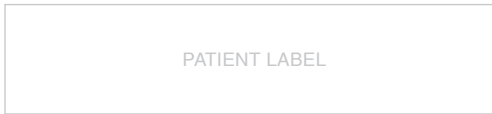
Healthcare Card required for appointment

Name _____ M F

DOB _____ Insurance/WCB # _____

Phone _____

Address _____



APPOINTMENT

Date _____

Time _____

LOCATION

Moose Jaw

36 Athabasca St West S6H 2B5
P: 306-691-8880 F: 306-691-8885
MON-FRI 8:00-4:30 pm

CLINICAL HISTORY

X-RAY EXAM REQUESTED

Location _____

ULTRASOUND

See back for exam preparation/instructions

General

- Abdomen
- Renal
- Pelvis
- Hernia
- Scrotum
- Neck/Thyroid
- Soft Tissue

Chest

- Chest Wall
- Breast R L
- Axilla R L

Obstetrics

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

Cardiovascular

- Carotid
- Venous R L
- Arterial R L
- Echocardiogram

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

* Preliminary imaging performed when required

Technologist Use Only

Date _____

Tech _____ # Images _____

Shield Y N LMP _____

Remarks _____

Previous on PACS Y N

Location _____

PRACTITIONERS INFORMATION

Practitioners Name _____

Signature _____

Phone/Fax _____

Copy To _____

Stat Phone Report

P: _____

Stat Fax Report

F: _____

Send Patient with Images (CD Copy)

PRACTITIONERS STAMP/ID

