Canadian Radiology Center

ULTRASOUND BREAST IMAGING X-RAY REQUISITION

TARADALE LOCATION
6520 Falconridge Blvd NE #530,
Calgary, AB, T3J 3W6
Phone: 403-475-3800
Fax: 403-475-3802

NOLAN HILL LOCATION
155 Nolanridge Ct NW #210,
Calgary, AB, T3R 1W7
Phone:587-755-0011
Fax:587-755-0012

PATIENT INFORMATION

Date of Request (D/M/Y): _____ Home Phone: _____

Name: _____ ☐ Female ☐ Male Other Phone: _____

Address: _____ Date of Birth(D/M/Y): _____

City: _____ Province: _____ Postal Code: _____ AHC or WCB #: _____

PATIENT HISTORY

_____

_____

☐ Urgent ☐ Stat* * If fax or phone stat report required, please provide the numbers: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Practitioner's ID/Stamp:

Copy to: _____ WCB - Alberta

Phone: _____ Fax: _____ ☐ Send images with patient (CD copy)

Address: _____ Signature: _____

SERVICES

ULTRASOUND

☐ Routine Abdomen
☐ Limited Abdomen (1-2 organs)
Specify: _____
☐ KUB (Prostate is included in male)
☐ Female: Gyne & KUB
☐ Female: Gyne only
☐ Scrotum
☐ Head and Neck
☐ Thyroid
☐ Abdominal Wall
Site: _____
☐ Groin: ☐ R ☐ L
☐ Soft Tissue
Site: _____

OTHER

☐ _____
_____
_____
_____

MUSCULOSKELETAL

☐ Shoulder	☐ R	☐ L
☐ Elbow	☐ R	☐ L
☐ Wrist	☐ R	☐ L
☐ Hand	☐ R	☐ L
☐ Hip	☐ R	☐ L
☐ Knee	☐ R	☐ L
☐ Ankle	☐ R	☐ L
☐ Achilles Tendon	☐ R	☐ L
☐ Foot	☐ R	☐ L
☐ Plantar Fascia	☐ R	☐ L

☐ Other: _____

VASCULAR

☐ Upper limb venous for DVT	☐ R	☐ L
☐ Lower limb venous for DVT	☐ R	☐ L
☐ Upper limb arterial	☐ R	☐ L
☐ Lower limb arterial with ABI	☐ R	☐ L

☐ Carotid Doppler
☐ AAA Screening
☐ Renal Doppler
☐ Liver Doppler

OBSTETRICAL

☐ Complete obstetric series (dating, nuchal, detailed)
☐ OB Dating, Viability (7-12 wks)
☐ Nuchal Translucency (11w+0d -13w+6d)
☐ Detail Anatomical Screening (18-20 wks)
☐ Biophysical Profile (>28wks)
☐ Other: _____

INTERVENTION

Specify procedure/anatomy

_____
_____

BREAST IMAGING

(Taradale Location)

☐ Complete Breast Assessment (Mammography and Breast US (If dense breast or as necessary))
☐ Screening Mammography (Includes Tomosynthesis)
☐ Diagonostic Mammography (Includes Tomosynthesis)
☐ Diagnostic Breast Ultrasound ☐ R ☐ L ☐ Bilateral

X_RAY

(NO APPOINTMENTS NECESSARY, WALK-IN BASIS)
Specify anatomy / Examination required:

_____
_____

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PATIENT INSTRUCTIONS

1. Please bring this document with you to the exam.
2. Please bring your valid Health Care Card.
3. Please arrive earlier than your scheduled exam time.
4. Please do not bring children requiring supervision to the exam.

EXAM PREPARATION

Home medications should be taken as usual.
Diabetic patients should consult with their physicians, and request an earlier appointment.

ABDOMEN:
Do not take anything by mouth (no drinking or eating) 6 hours before the appointment.

ABDOMEN AND PELVIS:
Drink and finish 1 liter (4 cups) of water 1 hour before the appointment.
Do not eat 6 hours before the appointment.

BLADDER, PELVIS, PREGNANCY LESS THAN 28 WEEKS:
Drink and finish 1 liter (4 cups) of water 1 hour before the appointment. Eat as usual.

PREGNANCY 28 WEEKS OR MORE:
Drink and finish 1/2 litre (2 cups) of water 40 minutes before the appointment. Eat as usual.

MAMMOGRAPHY:
Do not use deodorant, antiperspirant or talcum before the appointment.
Schedule your appointment when you have no premenstrual tenderness.
Wear a two-piece outfit.