

Patient Information				Physician Information	
First Name		Last Name		Name	
Home Phone		Other Phone		Address	
		M   F	DD / MM / YYYY	DD / MM / YYYY	Fax
OHIP	Version Code	Sex	Date of Birth	Date	

Appointment Date/Time		
DD / MM / YYYY		Please see Patient Instructions on back
Appointment Date	Appointment Time	24-hour notice required to cancel appointment or \$75 charge will be billed to patient.

X-Ray (No Appointment)		Ultrasound (By Appointment)		
<p><b>ABDOMEN</b></p> <input type="checkbox"/> ABD Series <input type="checkbox"/> KUB (single view) <p><b>HEAD &amp; NECK</b></p> <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nose <input type="checkbox"/> Mandible <input type="checkbox"/> Orbits <input type="checkbox"/> TM joints <p><b>CHEST</b></p> <input type="checkbox"/> Chest PA & LAT <input type="checkbox"/> Ribs <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B <small>(includes PA chest)</small> <input type="checkbox"/> Sterno - Clavicular Jts. <input type="checkbox"/> Sternum <input type="checkbox"/> Other: _____	<p><b>SPINE &amp; PELVIC</b></p> <input type="checkbox"/> Pelvis <input type="checkbox"/> Pelvis <input type="checkbox"/> R <input type="checkbox"/> L Hip <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar (L/S) Spine* <input type="checkbox"/> L/S Spine Pelvis <small>&amp; S.I. Joints*</small> <input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> S.I. Joints <input type="checkbox"/> Scoliosis <p><b>LOWER EXTREMITIES</b></p> <small>B = Bilateral</small> <small>B R L</small> <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Hip <input type="checkbox"/> Femur <input type="checkbox"/> Tib. & Fib. <input type="checkbox"/> Heel <input type="checkbox"/> Toe: 12345	<p><b>UPPER EXTREMITIES</b></p> <small>B = Bilateral</small> <small>B R L</small> <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Forearm <input type="checkbox"/> Humerus <input type="checkbox"/> Clavicle <input type="checkbox"/> A.C. Joints <input type="checkbox"/> Scapula <input type="checkbox"/> Scaphoid <input type="checkbox"/> Finger: 12345	<p><b>GENERAL</b></p> <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis Transvaginal <small>unless contraindicated</small> <input type="checkbox"/> Renal & Bladder <input type="checkbox"/> PVR - Post Void Residual <input type="checkbox"/> Transrectal Prostate <input type="checkbox"/> AAA Screening <input type="checkbox"/> Abdominal Wall <input type="checkbox"/> Inguinal Canal <input type="checkbox"/> Scrotum <input type="checkbox"/> Thyroid and Neck <p><b>BREAST</b> <input type="checkbox"/> B <input type="checkbox"/> R <input type="checkbox"/> L</p> <input type="checkbox"/> Other: _____	<p><b>MUSCULOSKELETAL</b></p> <small>B = Bilateral B R L</small> <input type="checkbox"/> Shoulder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbow <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wrist/Hand <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knee <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Popliteal Fossa <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Achilles Tendon <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ankle <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Plantar Fascia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps & Bumps <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hip <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p><b>Clinical History Requested</b></p> <input type="checkbox"/> WSIB <input type="checkbox"/> STAT		<p><b>Bone Mineral Densitometry (BMD)</b></p> <input type="checkbox"/> Baseline <input type="checkbox"/> 3yr - First follow-up <input type="checkbox"/> Date of Prior Study: <small>Low Risk: High Risk:</small> <input type="checkbox"/> 5 year <input type="checkbox"/> 1 year <small>(if known)</small>		
		<p><b>Gastrics (By Appointment)</b></p> <input type="checkbox"/> Upper GI <input type="checkbox"/> Esophagram <input type="checkbox"/> Upper GI and Small Bowel <input type="checkbox"/> Barium Enema		

Doctor's Signature: \_\_\_\_\_ Copy To: \_\_\_\_\_

## INSTRUCTION TO PATIENTS:

1. Please bring your health card and this paper with you to your appointment.
2. Please arrive 10 minutes early to register.
3. Please refer to the exam preparations below.

**Preparation & Instructions** These instructions are *IMPORTANT*. Please follow them. FHMI is a scent free environment.

### Ultrasound Preparation and Instructions

#### Abdomen

No eating or drinking (smoking or chewing gum) 4 hours prior to the appointment.

#### Obstetrical/Pelvis

A full bladder is necessary for a thorough examination of the pelvis and pregnant uterus.

START drinking 5 cups of water (40 oz. or 1.25 litres) or other fluid 2 hours before your examination.

FINISH drinking at least 1 hour prior to your examination.

Example: If your appointment is for 3:00 p.m., you should start drinking by 1:00 p.m. and finish drinking by 2:00 p.m.

**DO NOT** empty your bladder before your examination.

**Note: If your bladder is not full YOUR APPOINTMENT MAY HAVE TO BE RESCHEDULED**

#### Abdomen/Pelvis

No eating or drinking immediately prior to appointment.

START drinking 5 cups (40 oz. or 1.25 litres) of WATER ONLY 2 hours before your examination.

FINISH drinking at least 1 hour prior to your examination.

**DO NOT** empty your bladder before your examination.

#### Prostate (Transrectal)

**FLEET ENEMA** 2 hours before the examination (kit may be purchased at your pharmacy.)

Drink 34 oz. or 1 Litre of water 1 hour prior to appointment.

*Do not go to the washroom.*

### Bone Mineral Densitometry

Do not take calcium supplements for 24 hours prior to examination.

Patients are asked to wear clothing without zippers or metal attachments.

### Gastric Preparation and Instructions

#### Upper GI/Esophagus/Small Bowel

Nothing to eat or drink after midnight the evening prior to examination. No breakfast. No chewing gum.

Small bowel examination may take 1 - 3 hrs.

#### Barium Enema

The day before exam drink clear fluids only (fruit juice, clear broth, gelatin, popsicles, coffee or tea).

**At 4:00 pm**, drink the entire **CITROMAG** (available at pharmacy).

**At 6:00 pm** take **3 Dulcolax tablets**.

**Drink at least 5 large glasses of water** during the afternoon and evening prior to the examination.

The day of examination may have clear fluids until exam is completed.

**FHMI** FOREST HILL  
MEDICAL IMAGING

### Forest Hill Medical and Professional Building

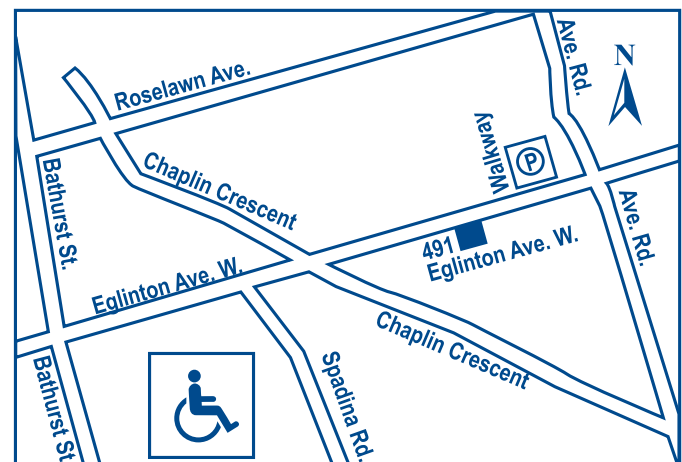
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