LONDON X-RAY ASSOCIATES
EST.1931

ULTRASOUND & ECHOCARDIOGRAMS

TO MAKE AN APPOINTMENT CALL OUR BOOKINGS DEPARTMENT
TEL: 519-672-7900 FAX: 519-672-8731 • Monday to Friday 8:00 a.m. to 4:45 p.m.
FOR ALL OTHER INQUIRIES AND IMAGE REQUESTS CALL 519-672-5270

PATIENT INFORMATION Requisition valid for 3 months after date issued

REFERRAL DATE: _____

NAME: _____ TELEPHONE: _____ DOB: _____

HEALTH CARD #: _____ VERSION CODE: ☐ ☐ ☐ M ☐ F WEIGHT: _____ LBS/KGS

APPOINTMENT DETAILS - Please arrive 10 minutes early. Bring your health card and this form to your appointment. Late arrival and/or no form may require re-booking.

DATE: _____ TIME: _____ LOCATION: _____

If you are unable to keep this appointment, please give at least 24 hours notice. Call 519-672-7900 **EXAM Preparations and MAPS on the back**

ULTRASOUND • BY APPOINTMENT (WEIGHT LIMIT 350LBS)

- ❒ Complete Abdominal & Limited Pelvic Ultrasound (Aorta, Gallbladder, Liver, Pancreas, Kidneys, Spleen, Lower Quadrants and Midline Pelvis)
- ❒ Complete Abdominal Ultrasound (Aorta, Gallbladder, Liver, Pancreas, Kidneys, Spleen)
- ❒ Limited Abdominal Ultrasound
  - ❒ Gallbladder ❒ Aorta ❒ Liver
  - ❒ Spleen ❒ Pancreas ❒ Kidneys (Renal)
- ❒ Bladder Only
- ❒ Male Pelvic Ultrasound (Prostate and Bladder)
- ❒ Female Pelvic Ultrasound with Transvaginal as required (Uterus, Ovaries and Bladder)
- ❒ Female Pelvic Ultrasound (Uterus, Ovaries and Bladder)
- ❒ Hernia
  - ❒ Inguinal ❒ Ventral ❒ Umbilical

Thyroid Ultrasound

- ❒ Thyroid Ultrasound *(with doppler)* - Suspected pathology **MUST** be indicated:
  - ❒ Nodules [L] [R] ❒ Thyroiditis
  - ❒ Masses [L] [R] ❒ Other, specify _____
- ❒ Thyroid Ultrasound *(without doppler)*
  - ❒ Change in Thyroid size, specify _____
  - ❒ Other, specify _____

Other Ultrasound

- ❒ Palpable lump. Specify location: _____
- ❒ Popliteal fossa (Baker's Cyst) [L] [R]

Scrotal/Testicular Ultrasound

- ❒ Scrotal/Testicular Ultrasound *(with doppler)* - Symptoms or suspected pathology **MUST** be indicated:
  - ❒ Torsion [L] [R] ❒ Pain [L] [R]
  - ❒ Mass [L] [R] ❒ Infection [L] [R]
  - ❒ Varicoceles [L] [R] ❒ Trauma [L] [R]
  - ❒ Other, specify _____
- ❒ Scrotal/Testicular Ultrasound *(without doppler)*
  - ❒ Other, specify _____

Vascular Ultrasound

- ❒ Carotid Artery Duplex Doppler
- ❒ Venous Reflux Study [L] [R]

Venous Leg Doppler (DVT) [L] [R]

Symptoms or suspected pathology **MUST** be indicated:

- ❒ Pain ❒ Swelling
- ❒ Trauma/recent surgery ❒ Skin redness/heat
- ❒ Past hx of DVT or PE
- ❒ Other, specify _____

Shoulder Ultrasound [L] [R]

- ❒ Shoulder Ultrasound *(with doppler)* - Suspected pathology **MUST** be indicated:
  - ❒ Pain ❒ Functional limitations ❒ Injury
  - ❒ Inflammation ❒ Other, specify _____
- ❒ Shoulder Ultrasound *(without doppler)*

ECHOCARDIOGRAMS • BY APPOINTMENT 450 CENTRAL ONLY (WEIGHT LIMIT 300LBS)

❒ **2D Echocardiogram with Colour/Doppler**

Indications (mandatory)

- ❒ Heart Murmur
- ❒ Valvular Stenosis/Regurgitation
- ❒ Mitral Prolapse
- ❒ Cardiac Structure Disease
- ❒ Prosthetic Heart Valves
- ❒ Infective Endocarditis
- ❒ Pericardial Disease
- ❒ Cardiac Masses
- ❒ Interventional Procedures
- ❒ Pulmonary Disease
- ❒ Coronary Artery Disease
- ❒ Dyspena, Edema, Cardiomyopathy
- ❒ Hypertension
- ❒ Thoracic Aortic Disease
- ❒ Myocardial Infarction
- ❒ Neurologic/Embolic Events
- ❒ Arrhythmias Syncope/Palpitations
- ❒ Before Cardioversions
- ❒ Suspected Structural Heart Disease
- ❒ Chest Pain
- ❒ Shortness of Breath
- ❒ R/O Cardiac Source of Stroke or TIA

HISTORY/CLINICAL FINDINGS (required): _____

_____

_____ ❒ Stat Call _____ ❒ Stat Fax _____

REFERRED BY: _____ **M.D.** **BILLING #** _____

PHYSICIAN ADDRESS: _____ **CC:** _____

VISIT OUR WEBSITE: www.lxa.on.ca

This requisition form can be taken to any licensed facility providing healthcare services, including independent health facilities (IHFs) and hospitals, such as those listed on the IHF Program website (http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx).

REV. 160519

PREPARATION AND INSTRUCTIONS: These instructions are **IMPORTANT**. Please follow them.

ULTRASOUND PREPARATIONS

❒ **Abdominal/Limited Pelvic Ultrasound**
- Morning
Nothing to eat or drink after midnight.
- Afternoon
One slice of dry toast, one cup of clear fluid not later than 8:00 a.m. on the day of examination.

❒ **Limited Abdominal Ultrasound**
- Gallbladder, Liver, Pancreas
Nothing to eat or drink 8 hours prior to exam time.
- Aorta, Spleen, Kidneys
Nothing to eat or drink 4 hours prior to exam time.

❒ **Renal/Pelvic Combination Ultrasound**
Your bladder must be full. DO NOT empty your bladder. **FINISH** drinking 5, eight ounce (250ml) glasses of water **1½ hours** prior to exam time.
***There are no fluid intake restrictions for this test due to the fact that your bladder must be full.**

❒ **Pelvic / Bladder Ultrasound**
A full bladder is necessary for a complete and proper exam. DO NOT empty your bladder. Your bladder must be full. There are no eating restrictions for this test. **FINISH** drinking 5, eight ounce (250ml) glasses of water **1½ hours** prior to exam time.
NOTE: No tampons to be worn for a female pelvic ultrasound.

SEE SEPARATE REQUISITION FOR GENERAL DIAGNOSTIC IMAGING & OBSTETRICAL IMAGING

FAILURE TO COMPLY WITH THE ABOVE PREPARATION INSTRUCTIONS MAY RESULT IN THE EXAMINATION HAVING TO BE RESCHEDULED.

104-450 Central Ave.	460 Springbank Dr.	440 Boler Rd.	595 Bradley Ave.	1657 Dundas St. E.
London, ON N6B 2E8	London, ON N6J 0A8	London, ON N6K 4L2	London, ON N6E 3Z8	London, ON N5W 3C6
Tel: 519-672-5270	Tel: 519-438-8131	Tel: 519-657-8246	Tel: 519-913-7900	Tel: 519-659-4158
Fax: 519-672-2724	Fax: 519-936-0089	Fax: 519-657-5439	Fax: 519-913-0429	Fax: 519-659-3294

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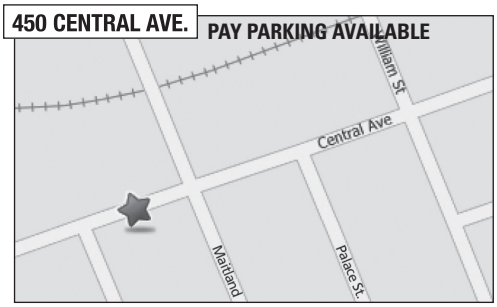
***Convenient Clinic Hours**
Including Evenings and Weekends!

450 CENTRAL AVE. PAY PARKING AVAILABLE



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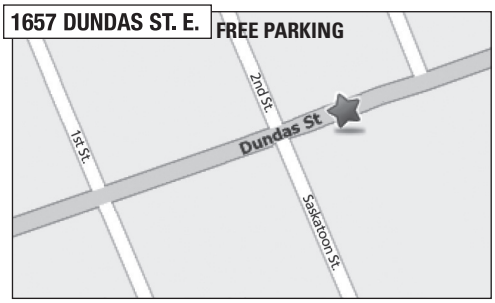
1657 DUNDAS ST. E. FREE PARKING



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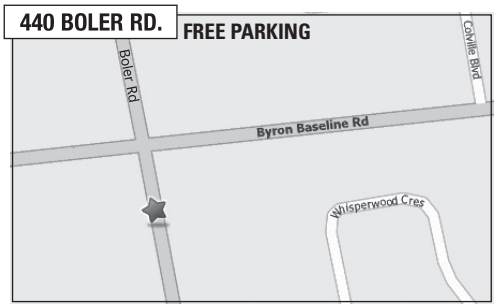
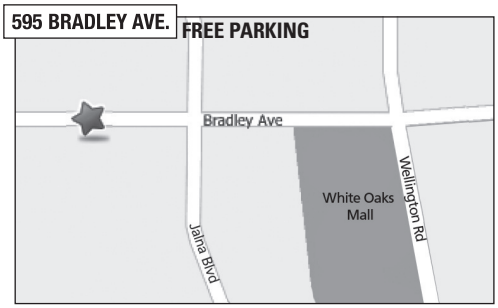


595 BRADLEY AVE. FREE PARKING



460 SPRINGBANK DR. PAY PARKING AVAILABLE