LIGHTHOUSE
MEDICAL IMAGING
info@lighthousemedical.ca
www.lighthousemedical.ca

EVENING + SATURDAY Hours Available For Most Procedures • ON-SITE RADIOLOGISTS

4190 Finch Avenue East, Unit #LL04
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FAX (416) 293-6036
我们有普通话服务。 我们有廣東話服务。

5 Fairview Mall Drive, Unit #100
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我们有普通话服务。我们有廣東話服务。 در محل فیرویو زبان فارسی حمایت میشود

REQUEST FOR EXAMINATION

OAR CBMD ACCREDITED FACILITY · CAR CANADIAN ASSOCIATION OF RADIOLOGISTS MAMMOGRAPHY ACCREDITED · obsp

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

ADDRESS _____ TOWN/CITY _____ POSTAL _____

PHONE ( ) _____ HEALTH CARD # _____ - _____ - _____ - _____ VERSION

DATE OF BIRTH DAY MONTH YEAR ☐ **Male** ☐ **Female**

APPOINTMENT DATE / TIME

APPT. DATE DAY MONTH YEAR

APPT. DAY (please circle the day): **MON TUE WED THU FRI SAT**

APPT. TIME _____

* Please provide 48 hours notice of cancellation.
$50 fee may be charged for missed appointment with no notice.

X-RAY

* no appointment or preparation required

* please advise staff if you are or may be pregnant

HEAD + NECK
- ☐ Sinuses
- ☐ Skull
- ☐ Facial Bones
- ☐ Nose
- ☐ Mandible
- ☐ TM Joints
- ☐ Adenoids
- ☐ Neck for Soft Tissue
- ☐ Orbits
- ☐ Orbits – Pre-MRI

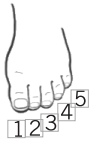
ABDOMINAL
- ☐ KUB (one view)
- ☐ Acute (two views) + PA Chest

CHEST
- ☐ Chest PA + LAT
- ☐ Chest PA Ins + Exp + Lat
- ☐ Sternum
- ☐ R Ribs + Chest PA
- ☐ L Ribs + Chest PA
- ☐ Immigration
- ☐ Chest PA

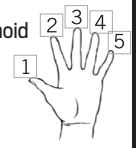
SPINE + PELVIS
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Sacrum + Coccyx
- ☐ S-I Joints
- ☐ Pelvis (one view)
- ☐ R Hip + Pelvis
- ☐ L Hip + Pelvis
- ☐ Scoliosis Series

SKELETAL SURVEY
- ☐ Arthritic
- ☐ Metastatic
- ☐ Bone Age

OTHER EXAMS OR VIEWS:
_____



UPPER EXTREMITIES
- ☐ R ☐ L Shoulder
- ☐ R ☐ L Clavicle
- ☐ Sternoclavicular Joints
- ☐ AC Joint
- ☐ R ☐ L Scapula
- ☐ R ☐ L Humerus
- ☐ R ☐ L Elbow
- ☐ R ☐ L Forearm
- ☐ R ☐ L Wrist
- ☐ R ☐ L Scaphoid
- ☐ R ☐ L Hand
- ☐ R ☐ L Digit



LOWER EXTREMITIES
- ☐ R ☐ L Hip
- ☐ R ☐ L Femur
- ☐ R ☐ L Knee
- ☐ R ☐ L Tibia + Fibula
- ☐ R ☐ L Ankle
- ☐ R ☐ L Foot
- ☐ R ☐ L Calcaneus
- ☐ R ☐ L Toes

ULTRASOUND

* by appointment, and see preparations at back

OBSTETRICAL
- ☐ Complete Obstetrical 18–20 weeks
- ☐ Dating
- ☐ High Risk
- ☐ Complications
- ☐ IPS (NT, 11-14 weeks)
- ☐ Biophysical Profile

PELVIC
- ☐ Transabdominal
- ☐ Transvaginal

ABDOMINAL
- ☐ Abdominal
- ☐ Abdomen + Pelvis

OTHER EXAMS:
_____

PROSTATE (incl. kidneys + bladder)
- ☐ Transabdominal
- ☐ Transrectal

SMALL PARTS
- ☐ Thyroid ☐ Neck
- ☐ Scrotum

MUSCULOSKELETAL
- ☐ R ☐ L Shoulder
- ☐ R ☐ L Elbow
- ☐ R ☐ L Wrist
- ☐ R ☐ L Hip
- ☐ R ☐ L Knee
- ☐ R ☐ L Ankle
- ☐ R ☐ L Foot
- ☐ R ☐ L Achilles/Plantar Fascia
- ☐ R ☐ L Lumps/Masses

bilateral imaging suggested

BIOPSY

- ☐ Thyroid FNA
- ☐ Ultrasound Guided Breast Biopsy
- ☐ Axillary Lymph Node Biopsy

BONE MINERAL DENSITY (DEXA)

* walk-ins welcome, appointment preferred

- ☐ BMD in accordance with Ministry of Health ordering guidelines

OAR CBMD ACCREDITED FACILITY

VASCULAR ULTRASOUND + CARDIAC TESTING

* by appointment, and see preparations at back

HEAD + NECK
- ☐ Arterial (Carotids + Vertebrals)

ABDOMEN
- ☐ Abdominal Aorta

EXTREMITIES (Peripheral Venous)
- ☐ Arm
- ☐ Leg: Superficial Venous **(Varicose Veins)**
- ☐ Leg: Deep Venous Sys. **(DVT)**

EXTREMITIES (Peripheral Arterial)
- ☐ Arm ☐ Leg with ankle-brachial indices

OTHER EXAMS:
_____

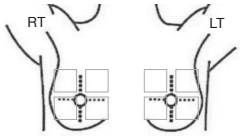
_____

CARDIAC TESTING
- ☐ Echocardiography ♥
  - ☐ LV function
  - ☐ Chest Pain
  - ☐ SOB
  - ☐ Palpitations
  - ☐ Arrythmia
  - ☐ Syncope
  - ☐ Hypertension
  - ☐ Vascular Heart Disease
  - ☐ Murmur
  - ☐ Cardiomyopathy
  - ☐ Other: _____

BREAST IMAGING

* by appointment, and see preparations at back

- ☐ Diagnostic Mammogram
  - ☐ Bilateral
  - ☐ Right
  - ☐ Left
  - ☐ Implants
- ☐ Ultrasound
  - ☐ Bilateral
  - ☐ Right
  - ☐ Left
  - ☐ Implants



- ☐ Contact patient directly if more views required
- ☐ Contact patient directly to book breast biopsy if required
- ☐ OBSP Screening
- ☐ Other: _____

Previous: ☐ Yes ☐ No

Where: _____

When: _____

CAR CANADIAN ASSOCIATION OF RADIOLOGISTS MAMMOGRAPHY ACCREDITED · obsp

CLINICAL HISTORY REQUESTED

- ☐ WSIB

- ☐ Interpretation of Chiropractic X-Rays Requested
- ☐ Consult requested for MRI/CT/Xray/Ultrasound

REFERRING PHYSICIAN ☐ STAT ☐ VERBAL

NAME OF DOCTOR _____ DOCTOR'S SIGNATURE _____

PHONE _____ FAX / EMERGENCY TEL. _____

DATE ISSUED: DAY MONTH YEAR

- ☐ Request CD
- ☐ **COPY TO:** _____ NAME _____ FAX # _____