

ONTARIO BREAST SCREENING PROGRAM SITE

PATIENT NAME

D.O.B.

HEALTH CARD NO.

PHONE #

ADDRESS

APPT DATE/TIME

X-RAY

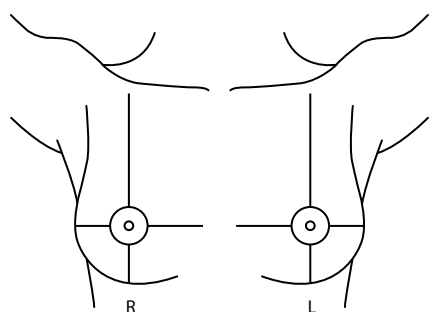
<input type="checkbox"/> CHEST	CLAVICLE	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> RIBS <table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	SHOULDER	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R
L	R					
L	R					
<input type="checkbox"/> CERVICAL SPINE	HUMERUS	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> THORACIC SPINE	ELBOW	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> LUMBAR SPINE	FOREARM	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> SACRUM/COCCYX	WRIST	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> SI JOINTS	HAND	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> PELVIS	FINGER No. ____	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> HIPS <table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R	FEMUR	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R
L	R					
L	R					
<input type="checkbox"/> ABDOMEN	KNEE	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> SKULL	TIB/FIB	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> FACIAL BONES	ANKLE	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> NASAL BONES	CALCANEUS	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> ORBITS	FOOT	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> SINUSES	TOE No. ____	<table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R		
L	R					
<input type="checkbox"/> SOFT TISSUE NECK						
<input type="checkbox"/> OTHER _____						

ULTRASOUND

<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> IPS		
<input type="checkbox"/> RENAL	<input type="checkbox"/> BIOPHYSICAL PROFILE		
<input type="checkbox"/> PELVIS	<input type="checkbox"/> THYROID		
<input type="checkbox"/> TRANSVAGINAL	<input type="checkbox"/> SCROTAL		
<input type="checkbox"/> OBSTETRICAL	<input type="checkbox"/> BREAST <table border="1"><tr><td>L</td><td>R</td></tr></table>	L	R
L	R		
<input type="checkbox"/> MSK <table border="1"><tr><td>L</td><td>R</td></tr></table> _____	L	R	<input type="checkbox"/> OTHER _____
L	R		

SEE REVERSE FOR IMPORTANT INSTRUCTIONS

DIGITAL MAMMOGRAPHY



<input type="checkbox"/> DIAGNOSTIC
<input type="checkbox"/> SCREENING
<input type="checkbox"/> OBSP

BONE MINERAL DENSITOMETRY ☐

*CLINICAL HISTORY/INDICATION:

PHYSICIAN'S SIGNATURE

VERBAL REPORT ☐

THIS DIGITAL MAMMOGRAPHY FACILITY IS ACCREDITED BY THE CANADIAN ASSOCIATION OF RADIOLOGISTS

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



PELVIC OR OBSTETRIC ULTRASOUND: Drink 5 large glasses of water (8 oz. size) to be FINISHED 1 HOUR BEFORE THE EXAMINATION. DO NOT EMPTY YOUR BLADDER.

ABDOMINAL ULTRASOUND: Nothing to eat or drink after midnight.

ABDOMINAL & PELVIC ULTRASOUND COMBINED:

Nothing to eat after midnight. Drink 5 large glasses of water (8 oz. size) to be FINISHED 1 HOUR BEFORE THE EXAMINATION. DO NOT EMPTY YOUR BLADDER.

BONE DENSITOMETRY: Do not take calcium tablets for 24 hours prior to the examination.

PLEASE BRING YOUR HEALTH CARD

YOU MUST BE ON TIME FOR YOUR EXAMINATION. IF YOU ARE MORE THAN 10 MINUTES LATE FOR YOUR APPOINTMENT YOU MAY BE RE-SCHEDULED.

