



PATIENT & APPOINTMENT INFORMATION

APPOINTMENT DATE

CHECK IN TIME:

APPT TIME:

PLACE PATIENT LABEL HERE

Name: Mickey Mouse AHC/WCB #: 00000-0000
Address: test City: test Province: AB Postal Code: T2H 2L8
☒ Female ☐ Male ☐ Undisclosed Date of Birth: 06/01/1969 Phone: (802)222-2222 Other Phone: _____

PATIENT HISTORY

- ☐ Stat Fax
☐ Stat Phone: _____
(Direct line/cell phone please)

Please provide as much detail as possible to allow us to provide the best care for the patient. Thank you.

Adult/Pediatric General Ultrasound

- ☐ Abdomen
☐ AAA Screening Only
☐ Liver Elastography (at Southtrail & Crowfoot)
☐ Pelvis ☐ Include kidneys
☐ Renal (Kidneys & Bladder)
☐ Thyroid
☐ Translabial (prolapse, incontinence, cystocele, or rectocele)
☐ Appendix
☐ Groin ☐ Inguinal Hernia ☐ Other indication
Inguinal hernia exams can only be ordered by a specialist or for a pediatric patient
☐ Abdominal Wall
☐ Scrotum/Testes
☐ Neck (salivary glands, lymph nodes)
☐ Lump/Soft Tissue
☐ Other: _____

Musculoskeletal Ultrasound

- ☐ Shoulder (Includes Rotator Cuff) ☐ R ☐ L ☐ Include X-Ray
☐ Elbow ☐ R ☐ L ☐
☐ Wrist (Includes Carpal Tunnel) ☐ R ☐ L ☐
☐ Hand or Finger ☐ R ☐ L ☐
☐ Hip ☐ R ☐ L ☐
☐ Knee (Includes Baker's Cyst) ☐ R ☐ L ☐
☐ Ankle ☐ R ☐ L ☐
☐ Achilles ☐ R ☐ L ☐
☐ Foot or Toe ☐ R ☐ L ☐
☐ Plantar Fascia ☐ R ☐ L ☐
☐ Muscle/Tendon: _____
☐ Ganglion: _____
☐ Other: _____

Obstetrical Ultrasound

To book exams throughout this pregnancy, please check all that apply.

- Date of last menstrual period: _____
☐ Complete Obstetrical Evaluation (Dating, Nuchal, Detailed)
☐ Include Cervical Length Screening (16-24 weeks)
1st Trimester
☐ Dating/Viability: _____
☐ Nuchal Translucency (11w 6d - 13w 6d)
2nd Trimester
☐ Detailed exam >18 weeks
3rd Trimester
☐ Biophysical Profile:
☐ OBS - Limited (Biometry, placenta, position, heart-rate)
☐ Other: _____

Vascular Ultrasound

- ☐ Carotid
(Including vertebral and subclavian arteries and Intima Media Thickness)
☐ Venous Doppler (Arm) ☐ R ☐ L
☐ Venous Doppler (Leg) ☐ R ☐ L
☐ Renal Doppler
☐ Temporal Artery Doppler
☐ Liver Doppler
Peripheral Arterial Screening:
☐ ABI (Ankle Brachial Index only)
☐ Lower Extremity Duplex with ABI
☐ Upper Extremity Duplex
☐ Other: _____

Bone Densitometry

- ☐ Bone Mineral Densitometry *Must meet guideline criteria
(Only available at South Trail and Airdrie locations)

X-Ray Examination (Walk in only)

No appointment necessary for x-ray, all other exams require appointment.

Right Knee Radiograph

IMPORTANT PATIENT INSTRUCTIONS ON REVERSE

Breast Imaging

- ☐ Complete Breast Evaluation
Includes mammography and breast ultrasound if indicated by breast density score. Ultrasound only added if Volpara C or D.
☐ Screening Mammography with Tomosynthesis
☐ Diagnostic Mammography with Tomosynthesis
☐ R ☐ L ☐ Bilateral
☐ Diagnostic Breast & Axilla Ultrasound
☐ R ☐ L ☐ Bilateral
☐ Axilla Only ☐ R ☐ L ☐ Bilateral

Intervention/Biopsies/FNA

PLEASE FAX THIS REQUISITION TO ANY OF OUR CLINICS

- ☐ Breast Biopsy ☐ R ☐ L
☐ Thyroid Biopsy ☐ R ☐ L
☐ FNA (specify side and site): ☐ R ☐ L

- ☐ Patient is on blood thinners.
Type: _____



Specialty Pediatric Ultrasound

- ☐ Bilateral Hips
(< 6 months adjusted age. If over 6 months an x-ray may be required)
☐ Cranial (Fontanelle must be open)
☐ Spine (< 6 months adjusted age)
☐ Pylorus (< 6 months)
☐ Joint(s) for effusions: _____

Pain Management Injections

Please refer to our specialized Pain Management requisition.

REFERRING PRACTITIONER INFORMATION

Referring Physician: Pureform Radiology
Clinic: _____
Address: _____
Phone: _____ Fax: _____
Copy to: _____ Copy to fax: _____
☐ Send images with patient (CD copy) Date of Request: D / M / Y

Practitioner's ID/Stamp:

Pureform Radiology

Signature: _____

Please List ALL Applicable Information Below