PUREFORM RADIOLOGY

Booking: 403-726-9729
www.MyPureform.com
Fax: 403-726-9883

GENERAL

PATIENT & APPOINTMENT INFORMATION | **APPOINTMENT DATE** | **CHECK IN TIME:** | **APPT TIME:**

PLACE PATIENT LABEL HERE

Name: Minnie Mouse AHC/WCB #: 00000-0000

Address: a City: a Province: AB Postal Code: T2H 2L8

☑ Female ☐ Male ☐ Undisclosed Date of Birth: 06 / 06 / 1901 Phone: (403)726-9729 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.

X-Ray Examination (Walk in only)

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

IMPORTANT PATIENT INSTRUCTIONS ON REVERSE

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

		Include X-Ray
☐ Shoulder (Includes Rotator Cuff)	☐ R ☐ L	☐
☐ 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)

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: _____

PURE kids. 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

Please List ALL Applicable Information Below

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: _____