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: _____ AHC/WCB #: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

☐ Female ☐ Male ☐ Undisclosed Date of Birth: D / M / Y Phone: _____ 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: _____ Practitioner's ID/Stamp:

Clinic: _____

Address: _____

Phone: _____ Fax: _____

Copy to: _____ Copy to fax: _____

☐ Send images with patient (CD copy) Date of Request: D / M / Y Signature: _____