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 #: 1111-111

Address: 1111 11 ave SW City: Calgary Province: AB Postal Code: T1T 1T1

☐ Female ☑ Male ☐ Undisclosed Date of Birth: 31 / 12 / 1999 Phone: (403)111-1111 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: Cat, Meow 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: _____

Rev. 11/2023