

**THORNHILL**

- ☐ **Thornhill Diagnostic Imaging** (UBMX)(OBSP)  
7330 Yonge Street, Suite 206  
Yonge/Clark  
PH: 905-889-5926 FAX: 905-881-6284

**MARKHAM**

- ☐ **Markham Ultrasound** (U)  
377 Church Street, Suite 305  
Church/Ninth Line  
PH: 905-472-4915 FAX: 905-472-1326
- ☐ **Markham Women's Imaging Centre**  
(UBM)(OBSP)  
39 Main Street North, Unit 1  
Markham/Highway 7  
PH: 905-472-2713 FAX: 905-472-9003

**TORONTO**

- ☐ **Bloor East Ultrasound** (U)  
160 Bloor Street East, 15<sup>th</sup> Floor  
Bloor/Church  
PH: 416-572-9392 FAX: 416-645-3286
- ☐ **Midtown Diagnostic Imaging** (UBMX)(OBSP)  
1849 Yonge Street, Lower Level  
Yonge/Davisville  
PH: 416-485-9155 FAX: 416-485-9532
- ☐ **North York Ultrasound** (UV)  
4025 Yonge Street, Suite 215  
Yonge/York Mills  
PH: 416-229-6887 FAX: 416-229-6614
- ☐ **Bay Street Ultrasound** (UV)  
655 Bay Street, 18<sup>th</sup> Floor  
Bay/Gerrard  
PH: 416-597-1933 FAX: 416-340-1218

- ☐ **Toronto West Ultrasound** (U)  
1560 Queen Street West  
Queen St. W/Jameson  
PH: 416-532-7948 FAX: 416-532-9291

**SCARBOROUGH**

- ☐ **Sheppard Diagnostic Imaging** (UBMX)  
1780 Markham Rd., Unit 5 & 6  
Sheppard/Markham  
PH: 416-291-4770 FAX: 416-291-9702

**ETOBICOKE**

- ☐ **Etobicoke Diagnostic Ultrasound** (U)  
110 Queen's Plate Drive  
Rexdale/Highway 27  
PH: 647-288-4547 FAX: 647-288-4550

**OAKVILLE**

- ☐ **Oakville Ultrasound** (U)  
2035 Cornwall Road  
Cornwall/Ford  
PH: 905-337-7202 FAX: 905-337-8294

(U) Ultrasound (X) X-RAY  
(M) Mammography  
(B) Bone Mineral Density  
(V) Vascular Ultrasound

# TRUE NORTH IMAGING

## IMAGING REQUISITION

**Dr. Alex Hartman and Dr. Rose Lee**  
Medical Directors of Imaging

www.truenorthimaging.com

### Greater Toronto Area Requisition

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ HIN: \_\_\_\_\_

Phone: \_\_\_\_\_

**ULTRASOUND**

- ☐ Abdominal ☐ G.U. Tract - Kidneys-Bladder(Prostate) ☐ Pelvic  
☐ Thyroid ☐ Scrotal ☐ Transvaginal  
☐ Musculoskeletal \_\_\_\_\_ ☐ RT ☐ LT ☐ Transrectal  
☐ Dating < 16 weeks ☐ NT 11-14 Weeks (IPS/eFTS) ☐ Fetal Growth ☐ Vascular  
☐ Anatomic 18-20 Weeks ☐ Biophysical Profile(BPP) ☐ Fertility Monitor Cycle  
☐ Sonohysterogram. Incl. Preliminary Female Pelvis Study  
☐ Sonohysterogram (Tubal Patency Investigation) Incl. Preliminary Female Pelvis Study  
☐ Other (Please specify): \_\_\_\_\_

**BREAST IMAGING**

- ☐ Mammogram ☐ Breast Ultrasound  
☐ BIL ☐ RT ☐ LT



☐ Ontario Breast  
Screening Program

**BONE DENSITOMETRY - AXIAL BONE DENSITOMETRY OF HIP AND SPINE**

- ☐ High Risk(Once a year) ☐ Routine(Every 5 Years)

**X-RAYS**

- | <b>CHEST</b>  | <b>ABDOMEN</b>                              | <b>Upper Extremities</b>                        | <b>LOWER EXTREMITIES</b>           |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Chest PA & Lat                                 | <input type="checkbox"/> KUB                | R L   | R L                                |
| <input type="checkbox"/> Chest PA                                       | <input type="checkbox"/> Acute ABD          | <input type="checkbox"/> Shoulder               | <input type="checkbox"/> Hip       |
| <input type="checkbox"/> Sternum  | <b>HEAD &amp; NECK</b>                      | <input type="checkbox"/> Clavicle               | <input type="checkbox"/> Femur     |
| <input type="checkbox"/> Ribs & Chest PA                                | <input type="checkbox"/> Orbits for Foreign | <input type="checkbox"/> AC Joint               | <input type="checkbox"/> Knee      |
| <input type="radio"/> B <input type="radio"/> R <input type="radio"/> L | <input type="checkbox"/> Body               | <input type="checkbox"/> Scapula                | <input type="checkbox"/> TIB/FIB   |
| <b>SPINE &amp; PELVIC</b>   | <input type="checkbox"/> Neck (Soft Tissue) | <input type="checkbox"/> Humerus                | <input type="checkbox"/> Ankle     |
| <input type="checkbox"/> Cervical Spine                                 | <input type="checkbox"/> Skull              | <input type="checkbox"/> Elbow                  | <input type="checkbox"/> Foot      |
| <input type="checkbox"/> Thoracic Spine                                 | <input type="checkbox"/> Orbits             | <input type="checkbox"/> Forearm                | <input type="checkbox"/> Toe       |
| <input type="checkbox"/> Lumbar Spine                                   | <input type="checkbox"/> Facial Bones       | <input type="checkbox"/> Wrist                  | Digit: 1 2 3 4 5                   |
| <input type="checkbox"/> Sacrum / Coccyx                                | <input type="checkbox"/> Nasal Bones        | <input type="checkbox"/> Scaphoid               | <input type="checkbox"/> OS Calcis |
| <input type="checkbox"/> Sacroiliac Joints                              | <input type="checkbox"/> Mandible           | <input type="checkbox"/> Bone Age, Hand & Wrist |                                    |
| <input type="checkbox"/> Scoliosis                                      | <input type="checkbox"/> TM Joints          | <input type="checkbox"/> Finger                 |                                    |
| <input type="checkbox"/> Skeletal Survey                                | <input type="checkbox"/> Adenoids           | Digit: 1 2 3 4 5                                |                                    |
| <input type="checkbox"/> Pelvis   |   | Other (Please Specify): _____                   |                                    |
| <input type="checkbox"/> Pelvis & Hips                                  |   |   |                                    |

**CLINICAL INFORMATION**


Referring Doctor: \_\_\_\_\_

Signature: \_\_\_\_\_

CC: \_\_\_\_\_

☐ STAT ☐ VERBAL Contact Number: \_\_\_\_\_

**PLEASE BRING THIS REQUISITION WITH  
YOU TO YOUR APPOINTMENT**

**You must follow instructions on  
reverse side**

- Please arrive 10 minutes prior to your appointment for registration.

- LATE arrivals may require re-booking.

Patient Information on Back



**IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT, PLEASE GIVE AT LEAST 24 HOURS NOTIFICATION.**

APPOINTMENT	MONTH	DAY	YR.	TIME
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**PREPARATION AND INSTRUCTIONS:** These instructions are **IMPORTANT**. Please follow them.

### **ULTRASOUND**

1. ABDOMEN (includes studies of the GALL BLADDER, PANCREAS, SPLEEN, LIVER, KIDNEYS and AORTA). If your appointment is in the morning, do not eat or drink anything after 8 p.m. the night before. If your appointment is in the afternoon, for breakfast you may eat dry toast, black tea, black coffee, juice up to 9 a.m. Nothing to eat or drink after that. These instructions are important as we require you to have an empty stomach.
2. PELVIS including TRANSVAGINAL (UTERUS, OVARIES, BLADDER) (also G.U. TRACT) and PREGNANCY (OBSTETRICAL). You must have **completed drinking** 1 hour before your appointment. Finish by \_\_\_\_\_. You must drink 32 oz./1 litre (4 large glasses) of fluids. This can include coffee, tea, juice, water, etc.- not milk.

**Do not go to the washroom.** You must have a full bladder for this examination. We will try to examine you as soon as possible on arrival so that you will not have to be uncomfortable for too long. Eat the meal nearest your examination - there is no reason not to eat.

3. ABDOMEN and PELVIS examinations combined.  
Do not eat anything 12 hours prior to the examination. Finish drinking 32 oz.(1 litre) of water, and **ONLY** water one hour before your examination. Finish drinking by \_\_\_\_\_. **Do not go to the washroom.**
4. PROSTATE WITH TRANSRECTAL  
32 oz./1 litre (4 large glasses) of water 1 hour before appointment. Do not go to the washroom. Finish by \_\_\_\_\_. Take mild laxative the evening before.  
(PROSTATE ONLY-OMIT LAXATIVE)

### **X-RAY**

5. Ladies who may be pregnant should not be x-rayed during the last two weeks of their menstrual cycle.

### **MAMMOGRAPHY**

6. On day of examination, after showering do not use deodorant, antiperspirant, or talcum powder on chest or underarms, since particles in these may show up on mammogram.

### **BONE MINERAL DENSITY**

7. On the day of examination do not take calcium supplements or iron tablets until after the examination is completed.

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>