



5-2683 Lawrence E, Scarborough, ON M1P 2S2
info.lmrc@torontovascular.com

2025 Midland Ave, Suite 200, 2nd Floor, Scarborough, ON M1P 3E2
info.me@torontovascular.com • www.midlandxrayandultrasound.com

Phone: 416-288-1333 | Fax: 416-288-1334

Phone: 416-296-1911 | Fax: 416-296-1910

PATIENT INFORMATION	APPOINTMENT DATE/TIME						
Last Name _____ First Name _____	Appt. Date <table style="display: inline-table; border: none;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">DAY</td><td style="text-align: center; font-size: 8px;">MONTH</td><td style="text-align: center; font-size: 8px;">YEAR</td></tr></table>				DAY	MONTH	YEAR
DAY	MONTH	YEAR					
Address _____ Town/City _____ Postal _____	Appt. Time _____						
Phone (____) _____ Health Card # _____ VERSION	*Please provide 48 hours notice of cancellation						
Date of Birth <table style="display: inline-table; border: none;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center; font-size: 8px;">DAY</td><td style="text-align: center; font-size: 8px;">MONTH</td><td style="text-align: center; font-size: 8px;">YEAR</td></tr></table> Male <input type="checkbox"/> Female <input type="checkbox"/>					DAY	MONTH	YEAR
DAY	MONTH	YEAR					

X-RAY *no appointment or preparation required *please advise staff prior to your exam if you are or may be pregnant.	ULTRASOUND *by appointment & see preparations at back
<p>HEAD + NECK</p> <input type="checkbox"/> Sinuses <input type="checkbox"/> Skull <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nose <input type="checkbox"/> Mandible <input type="checkbox"/> TM Joints <input type="checkbox"/> Adenoids <input type="checkbox"/> Neck for Soft Tissue <input type="checkbox"/> Orbits <input type="checkbox"/> Orbits - Pre-MRI <p>ABDOMINAL</p> <input type="checkbox"/> KUB <input type="checkbox"/> Acute Abdomen <p>CHEST</p> <input type="checkbox"/> Chest PA <input type="checkbox"/> Chest PA + LAT <input type="checkbox"/> Chest PA Ins + Exp + LAT <input type="checkbox"/> Sternum <input type="checkbox"/> SC Joint <input type="checkbox"/> R Ribs + Chest PA <input type="checkbox"/> L Ribs + Chest PA <input type="checkbox"/> Immigration <p>SPINE + PELVIC</p> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Lateral Thoracic + Lumbar Spine (> 20% compression fractures) <input type="checkbox"/> Sacrum + Coccyx <input type="checkbox"/> S-I Joints <input type="checkbox"/> Pelvis (One View) <input type="checkbox"/> R Hip + Pelvis <input type="checkbox"/> L Hip + Pelvis <p>SKELETAL SURVEY</p> <input type="checkbox"/> Arthritic <input type="checkbox"/> Metastatic <input type="checkbox"/> Bone Age <p>CLINICAL HISTORY / OTHER OR VIEWS:</p> <hr/> <hr/> <hr/> <hr/>	<p>UPPER EXTREMITIES</p> <input type="checkbox"/> R <input type="checkbox"/> L Shoulder <input type="checkbox"/> R <input type="checkbox"/> L Clavicle <input type="checkbox"/> AC Joints <input type="checkbox"/> R <input type="checkbox"/> L Scapula <input type="checkbox"/> R <input type="checkbox"/> L Humerus <input type="checkbox"/> R <input type="checkbox"/> L Elbow <input type="checkbox"/> R <input type="checkbox"/> L Forearm <input type="checkbox"/> R <input type="checkbox"/> L Wrist <input type="checkbox"/> R <input type="checkbox"/> L Scaphoid <input type="checkbox"/> R <input type="checkbox"/> L Hand <input type="checkbox"/> R <input type="checkbox"/> L Digit <div style="text-align: center;"> </div> <p>LOWER EXTREMITIES</p> <input type="checkbox"/> R <input type="checkbox"/> L Hip <input type="checkbox"/> R <input type="checkbox"/> L Femur <input type="checkbox"/> R <input type="checkbox"/> L Knee <input type="checkbox"/> R <input type="checkbox"/> L Tibia + Fibula <input type="checkbox"/> R <input type="checkbox"/> L Ankle <input type="checkbox"/> R <input type="checkbox"/> L Foot <input type="checkbox"/> R <input type="checkbox"/> L Calcaneus <input type="checkbox"/> R <input type="checkbox"/> L Toes <p>ABDOMINAL</p> <input type="checkbox"/> Abdominal <input type="checkbox"/> Abdomen + Pelvis <input type="checkbox"/> KUB <input type="checkbox"/> Liver Elastography (not covered by OHIP) <p>OBSTETRICAL</p> <input type="checkbox"/> Dating (6-12 weeks) <input type="checkbox"/> IPS (11-14 weeks) (Nuchal Translucency) <input type="checkbox"/> Anatomic (18-20 Weeks) <input type="checkbox"/> BPP (Biophysical Profile) <input type="checkbox"/> High Risk <input type="checkbox"/> Complications <input type="checkbox"/> 3D Obstetric Ultrasound (not covered by OHIP) <p>PELVIC</p> <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transvaginal <input type="checkbox"/> 3D Transvaginal Ultrasound <input type="checkbox"/> 3D Hysterosonogram <input type="checkbox"/> Transrectal Ultrasound (Prostate) <p>MUSCULOSKELETAL</p> <input type="checkbox"/> R <input type="checkbox"/> L Shoulder <input type="checkbox"/> R <input type="checkbox"/> L Elbow <input type="checkbox"/> R <input type="checkbox"/> L Neck <input type="checkbox"/> R <input type="checkbox"/> L Wrist <input type="checkbox"/> R <input type="checkbox"/> L Hand <input type="checkbox"/> R <input type="checkbox"/> L Knee <input type="checkbox"/> R <input type="checkbox"/> L Foot <input type="checkbox"/> R <input type="checkbox"/> L Achilles Tendon <input type="checkbox"/> R <input type="checkbox"/> L Hamstring <input type="checkbox"/> R <input type="checkbox"/> L Lumps/Masses <input type="checkbox"/> R <input type="checkbox"/> L Hernia <input type="checkbox"/> R <input type="checkbox"/> L Axilla <p>SMALL PARTS</p> <input type="checkbox"/> Parathyroid <input type="checkbox"/> Thyroid <input type="checkbox"/> Scrotum <p>CLINICAL HISTORY/OTHER:</p> <hr/> <hr/> <hr/> <hr/>

VASCULAR ULTRASOUND + CARDIAC TESTING *by appointment and see preparations at back	BREAST IMAGING *by appointment, and see preparations at back																				
<p>HEAD + NECK</p> <input type="checkbox"/> Carotid & Vertebral Arteries <input type="checkbox"/> Carotid Intimal Thickness <input type="checkbox"/> Stroke/TIA Protocol (Carotid, Vertebral, & Echocardiogram) <p>ABDOMEN</p> <input type="checkbox"/> Renal Arteries <input type="checkbox"/> Abdominal Aorta <input type="checkbox"/> Mesenteric Arteries <p>EXTREMITIES (Peripheral Arterial)</p> <input type="checkbox"/> Arm <input type="checkbox"/> Leg (ABI) <p>CARDIAC TESTING (Accredited by CorHealth Ontario)</p> <input type="checkbox"/> Echocardiography ♥ <p>INDICATIONS:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Palpitations</td> <td><input type="checkbox"/> LV Function</td> <td><input type="checkbox"/> Chest Pain</td> </tr> <tr> <td><input type="checkbox"/> Hypertension</td> <td><input type="checkbox"/> Arrythmia</td> <td><input type="checkbox"/> Syncope</td> </tr> <tr> <td><input type="checkbox"/> Murmur</td> <td><input type="checkbox"/> Vascular Heart Disease</td> <td><input type="checkbox"/> SOB</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Cardiomyopathy</td> <td><input type="checkbox"/> Other</td> </tr> </table> <p>EXTREMITIES (Peripheral Venous)</p> <input type="checkbox"/> Arm <input type="checkbox"/> Leg: Superficial Venous (Varicose Veins) <input type="checkbox"/> Leg: Deep Venous System (DVT) <input type="checkbox"/> Dialysis Fistula or Graft <input type="checkbox"/> R <input type="checkbox"/> L Arm <input type="checkbox"/> R <input type="checkbox"/> L Leg <p>CLINICAL HISTORY/OTHER:</p> <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Palpitations	<input type="checkbox"/> LV Function	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Arrythmia	<input type="checkbox"/> Syncope	<input type="checkbox"/> Murmur	<input type="checkbox"/> Vascular Heart Disease	<input type="checkbox"/> SOB		<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Other	<p>OBSP Screening <input type="checkbox"/> Ultrasound <input type="checkbox"/></p> <p>Diagnostic Mammogram <input type="checkbox"/></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Bilateral</td> <td><input type="checkbox"/> Bilateral</td> </tr> <tr> <td><input type="checkbox"/> Right</td> <td><input type="checkbox"/> Right</td> </tr> <tr> <td><input type="checkbox"/> Left</td> <td><input type="checkbox"/> Left</td> </tr> <tr> <td><input type="checkbox"/> Implants</td> <td><input type="checkbox"/> Implants</td> </tr> </table> <p><input type="checkbox"/> Contact patient directly if more views required <input type="checkbox"/> Other: _____</p> <p>Previous: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>When: _____</p> <p>Where: _____</p> <p>Clinical History: _____</p> <div style="text-align: right;"> </div>	<input type="checkbox"/> Bilateral	<input type="checkbox"/> Bilateral	<input type="checkbox"/> Right	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Left	<input type="checkbox"/> Implants	<input type="checkbox"/> Implants
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REFERRING PHYSICIAN ■ STAT ■ VERBAL + CLINICAL HISTORY REQUESTED	BONE MINERAL DENSITY (DEXA) *walk-ins welcome, appointment preferred
Name of Doctor _____ Doctor's Signature _____	<input type="checkbox"/> BMD in accordance with Ministry of Health ordering guidelines Accredited By:
Phone _____ Fax/Emergency Tel. _____	
<input type="checkbox"/> COPY TO: _____ NAME FAX#	
<input type="checkbox"/> Request CD Follow-up Frequency: _____	
Clinical History: _____	



PATIENT PREPARATION INSTRUCTIONS

ULTRASOUND PREPARATIONS

ABDOMEN, ABDOMINAL AORTA, RENAL ARTERIES
Avoid excess fats the night prior to the exam and solid foods 8 hours before the exam. Small quantities of clear fluids are permitted. (Any medication should be taken as required).

PELVIC ONLY - FEMALE & MALE
One hour prior to exam, drink 4 cups of water (total 32 oz). Do NOT empty bladder.

PROSTATE-TRANSRECTAL
The evening before the examination, take a fleet enema (purchased at the drug store). One hour prior to exam, drink 4 cups of water (total 32 oz). Do NOT empty bladder.

ABDOMEN & PELVIC - SAME VISIT
Avoid solid foods and excess fats 8 hours before the exam. Small quantities of clear fluids are permitted. One hour prior to the exam drink 4 cups of water (total 32 oz). Do NOT empty bladder.

PREGNANCY
One hour prior to the exam, drink the required amount of water:

under 12 weeks	4 cups (32 oz)
12-24 weeks	3 cups (24 oz)
over 24 weeks	2 cups (16 oz)

Adult Echocardiogram, Scrotum, Thyroid & Neck, Parathyroid, Salivary Glands, Neonatal Hips, Musculo-Skeletal, Cardiac Testing, Vascular Ultrasound (Head, Neck & Extremities), Mammography, BMD No preparation required.

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>

LAWRENCE & MIDLAND RADIOLOGY CENTRE

Ultrasound, X-ray and Bone Density
(No Vascular Ultrasound, No 3 D Ultrasound
No Mammography)

MIDLAND-ELLESMERE X-RAY & ULTRASOUND

All services available.

APPOINTMENTS

Please follow preparations carefully:

- We reserve the right to refuse and reschedule services due to circumstances such as arrival time, equipment downtime, patient/equipment weight capacities, etc.
- Please allow approx 45 minutes for each exam.
- Please arrive 20 minutes prior to your scheduled appointment time in order to register and to complete any necessary paperwork.
- 48 hours cancellation is required for cancellations otherwise a \$50 charge will apply.
- Reports will be sent to the referring physician within 1 to 24 hours.
- For urgent cases reports will be provided verbally and electronically within 3 hours or less.
- Ministry of Health guidelines restrict the release of reports directly to patients.

LAWRENCE & MIDLAND RADIOLOGY CENTRE

We are located on the South side of Lawrence.
North of Eglinton Ave E, steps away from either Midland Lawrence Plaza
Free Parking is available. Snow Free driving surfaces.
We are wheelchair accessible.



MIDLAND-ELLESMERE X-RAY & ULTRASOUND

We are located on the NE corner of Midland & Ellesmere.
South of Hwy 401, steps away from either the Midland RT station and close to Scarborough General Hospital. We are on the second floor of the Midland Professional building, suite 200.
Free Parking is available. Snow Free driving surfaces.
We are wheelchair accessible.

