Name:_____
Phone No.:_____
Address:_____
Date:_____D.O.B._____☐M / F☐
Health Card Number:_____
*****HCN needed when booking**

TEST	APPT. DATE	TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____

ESPANOLA REGIONAL HOSPITAL AND HEALTH CENTRE

DIAGNOSTIC IMAGING

Appointments Required prior to coming to hospital.
Phone: (705) 869-1420 ext. 3500 Fax: (705) 869-2211

ESPANOLA REGIONAL HOSPITAL AND HEALTH CENTRE HAS A NO SCENT POLICY.
Please refrain from the use of any/all perfumed products.
LE PROTOCOLE DE L'HÔPITAL RÉGIONAL ET CENTRE DE SANTÉ D'ESPANOLA EXIGE QUE VOUS NE PORTIEZ AUCUN PRODUIT PARFUMÉ

PROCEED TO REGISTRATION UPON ARRIVAL

X-RAY

SPINE
☐Cervical Spine
☐Soft Tissue Neck
☐Thoracic Spine
☐Lumbar Spine
☐S.I. Joints
☐Pelvis
☐Hip ☐R or L☐
☐Sacrum & Coccyx
☐Scoliosis series

THORAX
☐Chest
☐Ribs ☐R or L☐
☐SC Joints ☐R or L☐
☐Sternum
☐Shoulder ☐R or L☐
☐Clavicle ☐R or L☐
☐Scapula ☐R or L☐
☐A.C. Joints

UPPER EXT
☐Humerus ☐R or L☐
☐Elbow ☐R or L☐
☐Forearm ☐R or L☐
☐Wrist ☐R or L☐
☐Hand ☐R or L☐
☐Scaphoid ☐R or L☐
☐Thumb ☐R or L☐
☐Finger ☐R or L☐
☐2 ☐3 ☐4 ☐5

LOWER EXT
☐Femur ☐R or L☐
☐Knee ☐R or L☐
☐Patella ☐R or L☐
☐Tib / Fib ☐R or L☐
☐Ankle ☐R or L☐
☐Foot ☐R or L☐
☐Calcaneus ☐R or L☐
☐Toe ☐R or L☐
☐1 ☐2 ☐3 ☐4 ☐5
☐Leg Length studies

CRANIUM
☐Skull
☐Facial bones
☐Nasal bones
☐Mandible
☐TM joints
☐Eye for foreign Body

ABDOMEN
☐Acute Abdomen
☐KUB

FLUOROSCOPY
☐Joint Injection
Joint:_____
GASTRICS
☐GI Series *PREP1
☐BA Enema *PREP3
☐Small Bowel Fallow Through *PREP1

ULTRASOUND

GENERAL
☐Abdomen *PREP1
☐Complete
☐Kidneys
☐Liver
☐Pelvic *PREP2
☐Endovaginal *PREP2
☐Bladder *PREP2
☐OB Dating *PREP2
☐IPS(11w 0d – 13w 6d) *PREP2
☐OB Routine *PREP2
☐OB non routine *PREP2
_____

☐Soft Tissue
☐Groin ☐R or L☐
☐ Abdominal Wall
☐Other: _____
☐Breast ☐R or L☐
☐Thyroid
☐Testes

MUSKULOSKELETAL
☐Knee ☐R or L☐
☐Pop Fossa (Bakers Cyst) ☐R or L☐
☐Shoulder ☐R or L☐
☐Plantar Fascia ☐R or L☐
☐Ankle ☐R or L☐

VASCULAR
☐Lower Limb Arterial
☐Upper Limb Arterial
☐Carotid/Vert Arteries
☐Abdominal Grafts (Includes lower limb art) *PREP1
☐Raynaud / White Hands
☐Thoracic Outlet
☐Lower Limb Venous ☐R or L☐
☐Upper Limb Venous ☐R or L☐

☐Abd Aorta and Iliac Arteries *PREP1
☐Renal Arteries *PREP1
☐Mesenteric Arteries *PREP1
☐Impotence Assessment (Includes Lower Limb Arterial)
☐IVC Iliac Veins (includes Lower Limb Venous) *PREP1

☐Venous Mapping For:
☐CABG
☐ Lower Limb Bypass Graft
☐Upper Limb Dialysis Access
☐Follow Up for Significant Vascular Disease or Vascular Reconstruction:
Site_____
Frequency_____

*REQUIRES PREPARATION, SEE INSTRUCTION SHEET/ PREPARATION NECESSAIRE, VOIR PAGE D'INSTRUCTION

CARDIAC LAB

Bring list of all current medications
☐Echocardiogram
☐Treadmill Stress Test
☐Resting ECG
☐Holter Monitor (Includes ECG)
☐48 HR ☐72 HR ☐7 Day ☐14 Day

CLINICAL INFORMATION:_____

Family Physician:_____ Ordering Physician:_____

OFFICE USE ONLY
Pregnancy y☐ n☐
Technologist:_____

Additional Clinical Information/ Tech Comments:
_____
_____