



1854 SOUTHVIEW DRIVE, MEDICINE HAT
BOOKING LINE: 403 527 7334 EXT 1
BOOKING FAX: 403 527 9148

APPOINTMENT

YOU MUST ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TIME

YOU WILL BE BILLED \$50 PER MISSED APPOINTMENT

PATIENT NEEDS: OXYGEN WHEELCHAIR LIMITED ENGLISH HEARING IMPAIRED

PATIENT INFORMATION

NAME _____
DOB _____
GENDER _____
ADDRESS _____
CITY, PROV _____
POSTAL CODE _____
PHONE 1 _____
PHONE 2 _____
AHC# _____
WCB # _____ INJ DATE _____

HISTORY FOR REQUESTED PROCEDURE

*REQUIRED

PREVIOUS RELEVANT IMAGING

TOTAL BODY COMPOSITION (Patient Pay Exam)
 REPEATS

GENERAL RADIOGRAPHY (X-RAY)

SPECIFIC AREA/EXAM

BREAST IMAGING

PREVIOUS: WHERE/WHEN _____

IMPLANTS
 PREVIOUS BREAST CANCER

MAMMOGRAPHY

SCREENING BILATERAL
 DIAGNOSTIC L R

ULTRASOUND

SCREENING
 DIAGNOSTIC L R

BONE DENSITY

PREVIOUS: WHERE/WHEN _____

BASELINE
 2 YEAR SCREENING
 < 2 YEAR DIAGNOSTIC *specialist only

ULTRASOUND

<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> INGUINAL *specialist only
<input type="checkbox"/> ABD WALL/HERNIA	<input type="checkbox"/> EV
<input type="checkbox"/> PELVIC	<input type="checkbox"/> RENAL DUPLEX
<input type="checkbox"/> RENAL	<input type="checkbox"/> LMP/EDC _____
<input type="checkbox"/> SCROTAL	<input type="checkbox"/> F/U (when) _____
<input type="checkbox"/> OBSTETRIC	<input type="checkbox"/> BPP
<input type="checkbox"/> DATING	
<input type="checkbox"/> ROUTINE COMPLETE	
<input type="checkbox"/> THYROID	
<input type="checkbox"/> CAROTID DOPPLER	
<input type="checkbox"/> NECK	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> VENOUS DOPPLER	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> ARM <input type="checkbox"/> LEG	

MUSCULOSKELETAL ULTRASOUND

SHOULDER L R
JOINT OR LIMB L R
SOFT TISSUE MASS L R

DR. SIGNATURE: _____

COPIES TO: _____ FAX: _____

PRAC ID# _____

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GENERAL INSTRUCTIONS

- Arrive 15 minutes before your appointment time
- Bring identification including your VALID HEALTH CARE CARD
- Phone to cancel if you are unable to keep your booked appointment
- Please notify us if you are diabetic
- Patients suspecting pregnancy should consult their physician before exam date

CHILDREN UNDER 2 - NO PREP NEEDED

ABDOMEN - Fasting

RENAL DUPLEX - Fasting 12 hours, empty bladder

OBSTETRICAL - Full bladder

IUCD - Full bladder

PELVIC - Full bladder

RENAL - Full bladder

RENAL/PELVIC - Full bladder

ABDOMINAL/PELVIC - Fasting and Full bladder

ABDOMINAL/RENAL - Fasting and Full bladder

ABDOMINAL/PELVIC/RENAL - Fasting and Full bladder

ALL OTHER ULTRASOUND EXAMINATIONS - no preparation required

FASTING

Step 1- The evening before your exam, eat a low-fat supper. You may have a fat free snack after supper, but do not eat or drink anything after midnight.

Step 2- On the morning of your exam immediately, drink 2 (two) 8 oz. glasses of water. Do not substitute other liquids. You may empty your bladder.

FULL BLADDER

Eat and drink normally throughout the day then empty bladder 1 ½ hours before exam then;

ADULT: Drink 4 (four) 8 oz. glasses of water by 1 hour before exam. Do not empty bladder. Do not substitute other liquids.

CHILDREN 6-14: Drink 2 (two) 8 oz. glasses of water by 1 hour before exam. Do not empty bladder. Do not substitute other liquids.

CHILDREN 2-6: Drink 1 (one) 8 oz. glasses of water by 1 hour before exam. Try to hold bladder. Do not substitute other liquids.

IF YOU HAVE NOT FOLLOWED THE PREPARATION CORRECTLY YOUR EXAM WILL NEED TO BE RESCHEDULED