BIO-TEST RADIOLOGY SERVICES

www.bio-test.ca

❒ ROUTINE

❒ STAT

❒ **BELLS CORNERS**
2006 ROBERTSON RD., UNIT 16
OTTAWA, ON K2H 1A5
Tel: (613) 789-4242 Fax: (613) 789-7033
GENERAL X-RAY - ULTRASOUNDS & LAB SERVICES
8:00 A.M. - 4:00 P.M. (MON.-FRI.)

❒ **SMYTH MEDICAL CENTRE**
1929 RUSSELL RD., SUITE 102
OTTAWA, ON K1G 4G3
Tel: (613) 737-6872 Fax: (613) 737-6872
GENERAL X-RAY & LAB SERVICES
8:00 A.M. - 4:00 P.M. (MON.-FRI.)

(BOTH LOCATIONS CLOSED 12:00 - 1:00 P.M. FOR LUNCH)
**Depending on patient volumes, patients may stop being accepted before 4pm for X-rays*

REQUISITION FOR X-RAY AND ULTRASOUND
REQUISITION POUR RAYON-X ET ULTRASOND

DATE _____

Patient
Patient _____
SURNAME - NOM DE FAMILLE FIRST NAME - PRENOM

Address
Adresse _____ Tel _____

Insurance No.
No. d'assurance _____ Date of Birth
Date de Naissance _____

X-RAY CASE # **PREVIOUS CASE #**

No Appointment Required

CHEST
- ☐ Chest
- ☐ L ☐ R Ribs
- ☐ Sternum

SPINE & PELVIS
- ☐ Cervical Spine
- ☐ Dorsal Spine
- ☐ Lumbar (L/S) Spine
- ☐ Sacrum / Coccyx
- ☐ S.I. Joints
- ☐ Pelvis
- ☐ L ☐ R Hip

ABDOMEN
- ☐ Single View (K.U.B.)
- ☐ Acute (3 Views)

HEAD & NECK
- ☐ Skull
- ☐ Sinuses
- ☐ Facial Bones
- ☐ Nose
- ☐ Mandible
- ☐ T.M. Joints
- ☐ Mastoids
- ☐ Orbits/MR
- ☐ Adenoids

UPPER EXTREMITIES
- ☐ L ☐ R Clavicle
- ☐ A.C. Joints
- ☐ L ☐ R Shoulder
- ☐ L ☐ R Scapula
- ☐ L ☐ R Humerus
- ☐ L ☐ R Elbow
- ☐ L ☐ R Forearm
- ☐ L ☐ R Wrist
- ☐ L ☐ R Hand
- ☐ L ☐ R Finger
- ☐ Bone Age

LOWER EXTREMITIES
- ☐ L ☐ R Femur
- ☐ L ☐ R Knee
- ☐ L ☐ R Tib. & Fib
- ☐ L ☐ R Ankle
- ☐ L ☐ R Foot
- ☐ L ☐ R Toe No. _____
- ☐ L ☐ R Heel

X-RAY PREGNANCY RELEASE FORM

I declare, to the best of my knowledge, that I am NOT presently pregnant.

_____
Signature of Patient

By Appointment Only

- ☐ **Breast**
  - ☐ Bilateral
  - ☐ Lt ☐ Rt
- ☐ **Abdomen**
- ☐ **Pelvis**
- ☐ **Transvaginal**
- ☐ **Small Parts**
  - ☐ Thyroid
  - ☐ Neck
  - ☐ Scrotum/Testicles
  - ☐ Other _____
- **Obstetrical**
  - ☐ Routine ☐ LTD
  - ☐ Early Dating

Clinical History:

Name of Requesting Physician: _____

Address: _____ Phone: _____ Fax: _____

CC (Physician name & Address): _____

DATE: _____ **ORDERING DOCTOR'S SIGNATURE:** _____

NOTE: PLEASE BRING THIS PAPER AND YOUR HEALTH CARD WITH YOU
Please arrive 15 minutes prior to your appointment for registration. Late arrivals may require re-booking
SEE REVERSE - FOR PATIENT INSTRUCTIONS

PREPARATIONS:

NOTE: *PATIENTS WHO ARE NOT PROPERLY PREPARED MAY HAVE TO RE-BOOK THEIR APPOINTMENT.*

ABDOMINAL ULTRASOUND: AM Appointment: DO NOT eat, drink, smoke or chew gum after midnight PM Appointment: Light breakfast and remain fasting for 6 hours prior to appintment	**ECHOGRAPHIE ABDOMINALE:** AM EXAMEN: Ne rien manger, boire ou fumer après minuit PM EXAMEN: Petit dejeuner et demeurez à six heures aprés l'examen
PELVIC/OBSTETRICAL ULTRASOUNDS: Finish drinking 40 oz (5-7 glasses) of water one hour before your appointment DO NOT empty your bladder and you may eat regular meals ****if bladder is not full, another appointment may be required	**ECHOGRAPHIE PELVIENNE/OBSTÉTRIQUE:** Buvez 5-7 verres de huit onces de l'eau un heure precedant l'examen NE PAS uriner avant la fin de l'examen
ABDOMINAL & PELVIC ULTRASOUNDS: DO NOT eat for at least 6 hours prior to appointment. Finish drinking 40 oz of water 1 hour before your appontment. Keep bladder full.	**ECHOGRAPHIE ABDOMINALE ET PELVIENNE:** Ne rien manger ou fumer 6 heures précédant l'examen. Buvez 5-7 verres de huit onces de l'eau un heure précédant l'examen. NE PAS uriner avant la fin l'examen.

☐ **THYROID ULTRASOUND:** No preparation.

☐ **EXTREMITIES ULTRASOUND:** No preparation.

☐ **BREAST ULTRASOUND:** No preparation.

☐ **TESTICULAR ULTRASOUIND:** No preparation.

FOR ULTRASOUND APPOINTMENT

Please call (613) 789-4242

*All ultrasounds are performed at
2006 Robertson Road only

Appointment Date: _____

Time: _____