



**PORT PERRY 462 Paxton Street, Suite B07
IMAGING Port Perry, ON L9L 1L9**

Phone: 905-985-9727 Fax: 905-985-0479
www.portperryimaging.com

Accredited by CNN for Echocardiography Since 2016
Accredited for Mammography by the Canadian Association of Radiologist Since 1997
Accredited for Ultrasound by the American College of Radiology Since 1999
Fetal Medicine Foundation, Nuchal Translucency Screening Centre Since 2005
Ontario Breast Screening Program - Port Perry Affiliate Since 1997
Accredited for Bone Density by the Ontario Association of Radiologists Since 2008

OHIP Requires you present your health card and requisition at each visit

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs.

Name: _____
Address: _____
Phone: (day) _____ (eve.) _____

Date of Birth: _____ M F Other

Health Card/Version Code: _____

Your Appointment: _____ at _____

Please make necessary childcare arrangements during your exam; Children will not be allowed in the exam room

GENERAL AND OBSTETRIC ULTRASOUND APPOINTMENT REQUIRED

GENERAL ULTRASOUND:

- Abdomen Lt. Abdomen
- Abdomen Wall (mass/hernia)
- Female Pelvis
 - Transvaginal
- Male Pelvis (suprapubic only)
 - Transrectal (Prostate)
- Renal (kidneys)
- Other: _____

BILAT L R

- Breast
- Groin for Hernia
- Thyroid
- Neck for LNs or other mass
- Salivary Glands
- Scrotum
- Chest Wall

OBSTETRIC:

- 1st Trimester Dating
- eFTS 12w-13w6d (blood work)
- Nuchal Translucency 12w-13w6d
- Anatomic Survey (20-22 wks)
- _____ Previous c-sections
- BPP & Fetal Growth
- Fetal position
- Biophysical Profile
- Other _____

CARDIAC NUCLEAR IMAGING APPOINTMENT REQUIRED

- Exercise perfusion imaging (sestamibi)
- Persantine perfusion imaging (sestamibi)
- Resting radionuclide ventriculogram (MUGA)
- Thallium, rest and redistribution (for viability)

VASCULAR ULTRASOUND APPOINTMENT REQUIRED

- Bi-Lateral Carotid Doppler
- Renal Arterial Doppler
- ABI Only

BILAT L R

- Venous Doppler Lower Extremities
- Venous Doppler Upper Extremities
- Arterial Doppler Lower Extremities
- Arterial Doppler Upper Extremities

MUSCULOSKELETAL ULTRASOUND APPOINTMENT REQUIRED

BILAT L R	BILAT L R	BILAT L R
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Calves	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hip
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbow	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Achilles' Tendon	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thigh
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wrist and Hand	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ankle	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Groin
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hamstring	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Plantar Fascia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knee

BONE MINERAL DENSITY APPOINTMENT REQUIRED

*Patient weight restriction <300lbs

- Baseline (First BMD in Ontario)
- Low Risk (Once every 60 months)
- High Risk (Once every 12 months)

X-RAY NO APPOINTMENT REQUIRED

- Site: _____

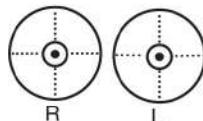
BREAST IMAGING APPOINTMENT REQUIRED

do not use deodorant, powders or cream on the breasts or underarms on the day of your exam

MAMMOGRAM

- Screening Papable Mass
- Other _____ Implants

BILAT L R
 Breast Ultrasound



CLINICAL INFO: _____

REF. MD.: _____

Physician Signature: _____

Billing: _____

CC: _____

Date: _____

PREPARATION FOR CARDIAC AND GENERAL NUCLEAR MEDICINE TESTS

**PLEASE DO NOT FORGET TO BRING YOUR
HEALTH CARD AND A LIST OF ALL MEDICATIONS
TO EACH APPOINTMENT**

Persantine Perfusion (Sestamibi) *Two Day Test*

- Please bring medications or list of medications on Day 1
- Light breakfast on Day 1 and day 2 but **No caffeine** (tea, coffee, cola, chocolate) for 24 hours prior to Day 2 including decaffeinated tea/coffee & Tylenol #3

Exercise Perfusion (Sestamibi) *Two Day Test*

- Please bring medications or list of medications on Day 1
- Light breakfast on Day 1 and day 2 but **No caffeine** (tea, coffee, cola, chocolate) for 24 hours prior to Day 2 including decaffeinated tea/coffee & Tylenol #3
- Be prepared to Exercise (walk or run) on the treadmill - wear a T-Shirt, shorts or sweatpants and running shoes.
- **If permitted by your doctor**, the following medications should be stopped prior to your test (only if you are having an exercise test):

- metoprolol (Lopressor)
- acebutolol (Monitan; Sectral)
- diltiazem (Cardizem; Tiazac)
- carvedilol (Coreg)
- bisoprolol (Monocor)
- sildenafil (Viagra)
- vardenafil (Levitra)

**STOP FOR 24 HOURS
BEFORE THE TEST IF
PERMITTED BY YOUR
DOCTOR**

- atenolol (Tenormin)
- nadolol (Corgard)

**STOP FOR 48 HOURS BEFORE THE
TEST IF PERMITTED BY YOUR
DOCTOR**

- tadalafil (Cialis)

**STOP FOR 72 HOURS
BEFORE THE TEST**

**THE ABOVE MEDICATIONS
MAY BE RESUMED AFTER THE TEST**

DURATION OF TESTS

TEST

Myocardial Perfusion Imaging (Sestamibi)

Bone Scan

Thyroid Scan

All Other Nuclear Scans

Ultrasound, Doppler and Echo

Bone Mineral Densitometry

APPROXIMATE DURATION

1.5 hours in am day one and 1.5 hours in am day two

10 minutes, then 1 hour following a 2-3 hour delay

15 minutes day one and 1 hour day two

1 hour on a single day (some require up to a 4 hour delay after injection)

40 minutes

20 minutes - do not take clacium pill morning of exam

**PLEASE BRING RESULTS OF OTHER RECENT TESTS, IF
DONE ELSEWHERE AND AVAILABLE.**

Biliary Scan

- Nothing to eat or drink for 4 hours prior to the scan

Thyroid Uptake and Scan

- If permitted by your doctor, stop Thyroxine 5 weeks before your test and stop Cytomel 3 weeks before your test
- No intravenous contrast material (CT, IVP or angiogram, and no seaweed (sushi)) for 5 weeks prior to your test
- Nothing to eat or drink for 4 hours prior to the scan.

Diabetics:

- If on oral medication, don't eat breakfast or take your diabetes medication the morning of the test. After the test, you may eat and take your medication
- If on Insulin, on the morning of the test, take half the normal dose and eat a light breakfast

