

DIAGNOSTIC IMAGING CONSULTATION REQUEST

Date: _____

For Appointments call: (905) 813-2731 or Fax to: (905) 813-4418

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Mammography | <input type="checkbox"/> Bone Density | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Special Procedures |
| <input type="checkbox"/> G.I. Series | <input type="checkbox"/> C.T. | |

- CT-Redirect to:**
-
-
- Trillium Health Centre
-
-
- HHS Oakville
-
-
- HHS Milton
-
-
- Any if waitlist is shorter

REGIONS TO EXAMINE

1. _____
-
2. _____
-
3. _____

Referring Physician: _____

Fax #: _____

L.M.P. _____

**PROBLEM FOR INVESTIGATION (PLEASE PRINT CLEARLY)
HISTORY / FINDINGS**

CC: _____ _____

 PHYSICIAN'S SIGNATURE

YOUR APPOINTMENT HAS BEEN SCHEDULED FOR: DAY _____ DATE: _____ TIME: _____
**CONTRAST INJECTION CHECKLIST
(To Be Completed By Imaging Personnel)**

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Previous Contrast Examination.....
Date: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Polycythemia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Pheochromocytoma .. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Previous Contrast Reaction.....
Date: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 5. Patient has read information in contrast
material brochure | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Allergy History: | | | 6. Contrast Used | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Amount: _____ | | |
| Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | 7. Injected By: _____ Time: _____ | | |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | 8. Reaction?: | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Other Risk Factors: | | | 9. Study Supervised By: _____ MD | | |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Myeloma | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Renal Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |



PATIENT PREPARATION FOR DIAGNOSTIC IMAGING PROCEDURES

(BRACKETED TIMES = APPROXIMATE DURATION OF PROCEDURES)
For Paediatric and other examinations NOT covered below, call (905) 813-4517

NUCLEAR MEDICINE

- Bone Scan** (4 Hours)
No preparation required.
- Biliary Scan** (1-2 Hours)
DO NOT eat or drink 4 hours prior to examination
- Schillings Test** (2 Day Test)
DO NOT eat or drink 4 hours prior to the examination.
Check with your doctor about stopping Vit. B12 prior to your test.
- Thyroid or Parathyroid Scans** (2 Day Test)
DO NOT eat or drink 4 hours prior to the examination.
No x-ray contrast media ("dye") within 4 weeks of your scan; if on thyroid medication please check with your doctor
- Renal (Kidney) scan for High Blood Pressure**
Omit breakfast. Check with your doctor if you are taking blood pressure medication
- Renal (Kidney) scan: Routine/Diuretic**
Drink 4 glasses of water during the 1 hour before your test. Urinate as needed.

GI

- Esophagus, Stomach & Duodenum G.I. Series** (1 Hour)
DO NOT eat or drink after 10:00 p.m. the night before before the examination.
- Small Bowel Follow Through** (1-3 Hours)
DO NOT eat or drink after 10:00 p.m. the night before before the examination.
- Barium Enema** (2 Hours)
Preparation pamphlet to be given by Physician's Office or picked up at hospita

CT

- HEAD** **DO NOT** eat or drink for 2 hours prior
- ABDOMINAL** **DO NOT** eat or drink for 4 hours prior

MAMMOGRAPHY (30 Minutes)

- DO NOT** use deodorant or talcum powder.
Wear a 2 piece outfit.

GU

- Intravenous Pyelogram I.V.P.** (1 Hour)
Clear fluid breakfast if morning appointment. Regular breakfast and clear fluid lunch if afternoon appointment.

ULTRASOUND

- Abdomen (Gall Bladder, Liver, Pancreas, Spleen, Kidney and Aorta)**
DO NOT eat or drink anything for 12 hours before your appointment. Avoid gas producing foods such as beans and carbonated beverages for 24 hours before the examination. There will be less gas if you refrain from smoking and chewing gum for 12 hours. Patients on medication may take it with a small amount of water. Insulin dependent diabetics should take their insulin with dry toast and juice.
- Obstetrical and Pelvis**
Your bladder must be full. Therefore 2 hours before the examination empty your bladder, then drink FOUR LARGE GLASSES of water / or some other CLEAR liquid. You must have completed drinking 1 hour before your examination. YOU MAY EAT.
- Thyroid, Neck, Testicles**
No preparation is necessary.
- Transrectal**
You must administer a fleet emema to yourself 1 hour before the examination. This may be purchased at any drug store.
- NOTE:**
 1. There is no known harmful effect to adult, child or fetus.
 2. No X-rays are used.
 3. Examination time usually varies from 30 to 60 minutes.
 4. The examination is usually not painful.

