Patient/Appointment Information

Healthcare Card required for appointment

NAME ______ ☐ M ☐ F

DOB ______ Insurance/WCB # ______

Address ______ Appointment Info ______

Phone ______ Date ______ Time ______

Locations - Scan the QR Code for directions

Leduc
5201 50 Street
Leduc, AB T9E 6T4
P: 780-612-5134
F: 780-612-0364
MON - FRIDAY: 8:00 - 4:30 PM

Camrose
#1 - 6601 48 Ave
Camrose, AB T4V 3G8
P: 780-672-8220
F: 780-672-8250
MON - FRIDAY: 8:30 - 4:30 PM

Wetaskiwin
4919 50 Street
Wetaskiwin, AB T9A 1J6
P: 587-468-8344
F: 587-468-0169
MON - FRIDAY: 8:00 - 4:30 PM

Ponoka
4502 50 Street
Ponoka, AB T4J 1J5
P: 587-492-1963
F: 403-704-2988
MON - FRIDAY: 9:00 - 4:30 PM

Clinical History

X-ray Exam Requested

Location

Ultrasound

See back for exam preparation/instructions

General
- ☐ Abdomen
- ☐ Renal
- ☐ Pelvis
- ☐ Hernia
- ☐ Scrotum
- ☐ Neck/Thyroid
- ☐ Soft Tissue

Chest
- ☐ Chest Wall
- ☐ Breast ☐R ☐L
- ☐ Axilla ☐R ☐L

Obstetrics
- ☐ (Early/NT/Detailed)
- ☐ 1st Timester
- ☐ Nuchal Translucency
- ☐ Routine (>18 wk)
- ☐ 2nd Trimester OB
- ☐ 3rd Trimester OB
- ☐ Biophysical (BPP)

Cardiovascular
- ☐ Carotid
- ☐ Venous ☐R ☐L
- ☐ **Echocardiogram**

Musculoskeletal*
- ☐ Shoulder ☐R ☐L
- ☐ Elbow ☐R ☐L
- ☐ Wrist ☐R ☐L
- ☐ Hand ☐R ☐L
- ☐ Hip ☐R ☐L
- ☐ Knee ☐R ☐L
- ☐ Ankle ☐R ☐L
- ☐ Foot ☐R ☐L
- ☐ **Proceed with therapeutic injection if appropriate**
- ☐ **Other Ultrasound** ______

Pain Therapy / Procedures*

☐ **Radiologist Consultation**
The most appropriate study/procedure will be arranged

Repeats No. Times ☐

Spine
- ☐ Epidural Injection
- ☐ SI Joint(s) ☐R ☐L
- ☐ Nerve Root Block ☐R ☐L
- Level: ______
- ☐ Facet(s) Cervical ☐R ☐L
- Thoracic ☐R ☐L
- Lumbar ☐R ☐L
- Level: ______
- ☐ MBB/RFA (facet(s) location above)
- ☐ Coccyx

Musculoskeletal
- ☐ Shoulder ☐R ☐L
- ☐ Elbow ☐R ☐L
- ☐ Wrist ☐R ☐L
- ☐ Hand ☐R ☐L
- ☐ Hip ☐R ☐L
- ☐ Knee ☐R ☐L
- ☐ Ankle ☐R ☐L
- ☐ Foot ☐R ☐L
- ☐ Other ______

Special Procedures
- ☐ Prolotherapy ☐ Barbotage
- Location: ______ ☐R ☐L
- ☐ Platelet Rich Plasma (private service)
- Location: ______ ☐R ☐L
- ☐ Aspiration +/- Injection
- Location: ______ ☐R ☐L
- ☐ **Other Procedure Requested** ______

Breast Imaging
- ☐ Complete Breast Assessment (Mammo and Breast US as applicable)
- ☐ Screening Mammography (with Tomosynthesis)
- ☐ Screening Breast Ultrasound ☐R ☐L ☐Bilateral
- ☐ Diagnostic Mammography (with Tomosynthesis) ☐R ☐L ☐Bilateral
- ☐ Diagnostic Breast Ultrasound ☐R ☐L ☐Bilateral
- ☐ US Guided Breast Biopsy

Bone Densitometry
- ☐ Baseline
- ☐ >2 yr follow-up
- ☐ <2 yr follow-up (applicable risk factors required)
- ☐ Body Composition (private service)

< 50 yrs (must have referral from AMA approved specialist)

Risk Factors
- ☐ Monitored "bisphosphonate holiday"
- ☐ Therapy with potential drug effect
- ☐ Post Transplant
- ☐ Hyperparathyroidism
- ☐ Supraphysiologic prednisone > 12 months

Nuclear Medicine
- ☐ Bone Scan (SPECT/ CT as needed)
  ______ Specify Applicable Area(s)
- ☐ Renal Scan ☐ Parathyroid
  - ☐ Diuretic
- ☐ HIDA Scan ☐ Gastric Empyting

MRI* (Private Service)

Exam: ______ ☐R ☐L

Contraindications for MRI: ☐Y ☐N

If Yes, Please Specify: ______

Gastrointestinal
- ☐ UGI (esophagus, stomach, duodenum)
- ☐ Small Bowel Follow Through

Cardiac
- ☐ Exercise Stress Test
- ☐ Myocardial Perfusion Imaging: ☐ Excercise ☐ Persantine

Practitioners Information

Practitioners Name ______

Signature ______

Phone/Fax ______

Copy To ______

- ☐ Stat Phone Report
  P: ______
- ☐ Stat Fax Report
  F: ______
- ☐ Send Patient with Images (CD Copy)

Technologist Use Only

Date ______

Tech ______

Images ______

Shield ☐ Y ☐ N LMP ______

Remarks ______

Relevant Prior ☐ Yes ☐ No

Date: ______

Exam: ______

www.guardrad.com : info@guardrad.com www.canadadiagnostics.ca

*Preliminary imaging performed when required