RADIMED

www.radimed.ca

PATIENT INFORMATION

First and last name _____

Date of birth _____

Home phone number _____

Cellular phone number _____

E-mail _____

☐ **Pregnant** Advise the Technologist BEFORE the exam.

REFERRING PHYSICIAN INFORMATION

First and last name _____

Doctor's signature _____

Date _____ Lic. # _____

Report : ☐ french ☐ english

☐ CNESST ☐ SAAQ File # _____

CLINICAL INFORMATION (MANDATORY)

A Westmount Square

B Saint-Laurent

C West-Island

D Vaudreuil-Dorion

E Valleyfield

F Trois-Lacs

G Pierrefonds

GENERAL RADIOLOGY A B C D E F G without appointment

CHEST & ABDOMEN

- ☐ Chest
- ☐ Ribs L R
- ☐ Sternum
- ☐ KUB
- ☐ Abdomen series

SPINE

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum & Coccyx
- ☐ S.I. joints
- ☐ Scoliosis series

HEAD & NECK

- ☐ Skull
- ☐ Facial bones
- ☐ Nose
- ☐ Neck soft tissues
- ☐ Mandible
- ☐ Orbits

SKELETAL SURVEY & BONE AGE

- ☐ Metastatic survey
- ☐ Arthritic survey
- ☐ Metabolic survey
- ☐ Bone age

UPPER EXTREMITIES

- ☐ Acromioclavicular joints
- ☐ Sternoclavicular joints
- ☐ Clavicle L R
- ☐ Scapula L R
- ☐ Shoulder L R
- ☐ Humerus L R
- ☐ Elbow L R
- ☐ Forearm L R
- ☐ Wrist L R
- ☐ Scaphoid L R
- ☐ Hand L R
- ☐ Finger L R

1 2 3 4 5

LOWER EXTREMITIES

- ☐ Pelvis
- ☐ Hip L R
- ☐ Femur L R
- ☐ Knee L R
- ☐ Patella L R
- ☐ Tib fib L R
- ☐ Ankle L R
- ☐ Foot L R
- ☐ Heel L R
- ☐ Toe L R

1 2 3 4 5

- ☐ Weight bearing views

SCANOGRAM

☐ Standing A C ☐ Lying down

MAMMOGRAPHY A C D E G with appointment

- ☐ Diagnostic
- ☐ Screening*

* RAMQ covers only 1 exam per year

PROCEDURES / INTERVENTIONS A C D E with appointment

- ☐ Therapeutic arthrography ☐ Bursa ☐ Intra-articular
  Region _____ L R
- ☐ Shoulder distensive arthrography L R
- ☐ Facet block level _____ L R
- ☐ Infiltration under US Region _____ L R
- ☐ Calcific Lavage
- ☐ PRP Infiltration A Region _____

CT scan A B with appointment

- ☐ Angiography _____
- ☐ Brain
- ☐ Sella turcica & Pituitary
- ☐ I.A.C. & Mastoids
- ☐ Orbits
- ☐ Sinuses
- ☐ Facial bones
- ☐ T.M. Joints
- ☐ Neck (ENT)
- ☐ Cardiac Scoring
- ☐ Cervical spine
- ☐ Thoracic spine
- ☐ Lumbar spine
- ☐ S.I. Joints
- ☐ Sacrum-coccyx
- ☐ Chest
- ☐ Abdomen & Pelvis
- ☐ Enterography
- ☐ Virtual Colonoscopy
- ☐ Dentascan _____
- ☐ CT Coronarography
- ☐ MSK _____ L R
- ☐ Foraminal block level _____ L R
- ☐ Epidural block level _____ L R
- ☐ CT-Arthrography _____ L R
- ☐ Full Body Scan (included MRI head / neck / abdo-pelv plus CT Scan screening chest with Cardiac scoring plus Ultrasound carotid / thyroid / breasts for women)
- ☐ Others _____

DIGESTIVE RADIOLOGY A C D E with appointment

- ☐ Barium Swallow ☐ Upper G.I.
- ☐ SBFT (Small Bowel Series) ☐ Barium Enema

BONE DENSITOMETRY A C D E G with appointment

- ☐ Bone Densitometry RAMQ covers only 1 exam per year

ULTRASOUND A B C D E F G with appointment

- ☐ Abdominal ☐ Breast(s) L R
- ☐ Pelvic ☐ Prostate
- ☐ Endovaginal ☐ Testicles
- ☐ Neck & Thyroid
- ☐ OBS ☐ Dating ☐ Nuchal Tr. ☐ 1st ☐ 2nd ☐ 3rd trim.
- ☐ MSK region _____ L R
- ☐ Surface region _____ L R
- ☐ Doppler _____ L R
- ☐ Echocardiogram A

MAGNETIC RESONANCE A B C with appointment

- ☐ Brain
- ☐ Pituitary gland
- ☐ I.A.C. / mastoids
- ☐ Facial bones
- ☐ Orbits
- ☐ T.M. Joints
- ☐ Sinuses
- ☐ Neck (ENT)
- ☐ Salivary gland
- ☐ Angiography _____
- ☐ Cervical spine
- ☐ Thoracic spine
- ☐ Lumbar spine
- ☐ S.I. Joints
- ☐ Sacrum-coccyx
- ☐ Brachial Plexus
- ☐ Lumbar Plexus
- ☐ Abominal
- ☐ Pelvis
- ☐ Prostate
- ☐ Iron/fat quantific.
- ☐ Defecography
- ☐ Enterography
- ☐ Breasts
- ☐ MSK region _____ L R
- ☐ MR Arthrogram region _____ L R
- ☐ Full Body Scan (included MRI head / neck / abdo-pelv plus CT Scan screening chest with Cardiac scoring plus Ultrasound carotid / thyroid / breasts for women)
- ☐ Others _____

SEE AT THE BACK

Address
telephone #
fax #
E-mail
for each clinic

INSTRUCTIONS FOR YOUR EXAM

ABDOMINAL ULTRASOUND: Fasting since midnight the day before if your exam is in the morning. Fasting 6 hours before if your exam is in the afternoon. Fat free breakfast.

PELVIC ULTRASOUND: Drink 750 ml of water. Please start 1h30 before the exam, do not urinate.

MAMMOGRAM: No deodorant, antiperspirant, powder or body lotion under your arms or on your breasts.
* Our mammography clinics are accredited PQDCS.

BONE DENSITOMETRY: Avoid taking calcium tablets, Tums, Rolaids 24 hours before the exam. You must wait 10 days after having a barium or nuclear medicine examination.

CARDIAC SCORING: Take B-blocker Tenormin 50 mg 4 hours before the exam, as prescribed by your doctor. No food or drink 4 hours before your exam. No caffeine and no smoking 12 hours prior to the exam. No exercise 24 hours before.

UPPER G.I.: Fasting 12 hours before your exam. No liquid, no food, do not smoke and do not chew gum before the exam.

SBFT: Allow a minimum of 3 hours to do this exam. Fasting 12 hours before the exam. No liquid or food, do not smoke and do not chew gum before the exam.

BARIUM ENEMA: Liquid diet (24 hours before the exam) clear soup (broth only), juice, jello, tea, coffee, no dairy products. Buy PURGODAN or PICO-SALAX at a drug store. Start to drink the laxative the day before the exam, the first dose at 8 a.m. and the second dose at 2 p.m. Drink a lot of water to stay hydrated while taking the laxatives. No fluid and no smoking after midnight.

CT SCAN ABDOMEN AND PELVIS: No food or drink 3 hours before the exam.

MRI WITH CONTRAST : No food or drink 3 hours before.

VIRTUAL COLONOSCOPY: The preparation related to this test will be explained to you when you make your appointment.

MRI SAFETY QUESTIONNAIRE

Pacemaker	Yes ☐	No ☐
Stent	Yes ☐	No ☐
Aneurysm clip	Yes ☐	No ☐
Ocular or cochlear implant	Yes ☐	No ☐
Breast implant or marker	Yes ☐	No ☐
Magnetic penile implant	Yes ☐	No ☐
Insulin pump, Blood glucose sensor	Yes ☐	No ☐
Neuro or biostimulator	Yes ☐	No ☐
Nicotine or medicated patch	Yes ☐	No ☐
Tinted contact lenses	Yes ☐	No ☐

Joint prosthesis	Yes ☐	No ☐
Hearing aid	Yes ☐	No ☐
Denture or teeth braces	Yes ☐	No ☐
Metal plate, screw, nail, staples or sutures	Yes ☐	No ☐
Shrapnel, bullet, gunshot	Yes ☐	No ☐
VP shunt	Yes ☐	No ☐
IVC filter (Birdnest)	Yes ☐	No ☐
Cotrel or Harrington rod	Yes ☐	No ☐
Metallic ocular foreign body	Yes ☐	No ☐
Tattoo, piercing or permanent makeup	Yes ☐	No ☐

Are you:
☐ Claustrophobic (if yes, have an Ativan prescription)
☐ Allergic (if yes, specify) _____
☐ Pregnant (if yes, how many weeks) _____
☐ Breastfeeding? (if yes, check)

Have you ever had surgery? (if yes, specify)

_____

_____

_____

WESTMOUNT SQUARE A

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WEST-ISLAND C

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Fax: 514-697-3711
Fax: 514-697-8854 – MRI only
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VAUDREUIL-DORION D

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TROIS-LACS F

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