



HBMI
HUMBER BAY
MEDICAL IMAGING

3101 Bloor Street West
Suite 103 Toronto, ON
tel. 416-239-3568
fax. 416-239-3569



ontario breast
screening program
a cancer care ontario program

email. help@hbmi.ca

website. www.hbmi.ca

Please bring this requisition form & a valid OHIP card to your appointment.

CLINICAL INFORMATION

Date: _____

PATIENT INFORMATION

Name: _____ Phone #: _____
Address: _____ Postal Code: _____
City: _____ Health Card #: _____ VC: _____
D.O.B.: _____ Pregnant Non-Pregnant

PHYSICIAN INFORMATION

Physician: _____ Signature: _____
Billing #: _____ CPSO #: _____
Report Delivery Preference: _____ Fax HRM
cc Physicians: _____ Urgent Stat
Phone: _____ Fax: _____

X-RAY (NO APPOINTMENT NEEDED — WE ACCEPT WALK-INS)

<p>CHEST</p> <input type="checkbox"/> CHEST PA & LAT <input type="checkbox"/> STERNUM <input type="checkbox"/> SC JOINTS <input type="checkbox"/> PA <input type="checkbox"/> AP <input type="checkbox"/> LAT <input type="checkbox"/> R L RIBS <p>ABDOMEN</p> <input type="checkbox"/> KUB <input type="checkbox"/> PLAIN <input type="checkbox"/> ACUTE (2 VIEWS) OTHER: _____	<p>HEAD & NECK</p> <input type="checkbox"/> SKULL <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> NASAL BONES <input type="checkbox"/> MANDIBLE <input type="checkbox"/> T.M. JOINTS <input type="checkbox"/> ADENOIDS <input type="checkbox"/> MASTOID <input type="checkbox"/> NECK FOR SOFT TISSUE <input type="checkbox"/> SELLA TRUCICA <input type="checkbox"/> ORBITS <input type="checkbox"/> SCOLIOSIS — CERVICAL OTHER: _____	<p>SPINE & PELVIS</p> <input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> FLEXION/EXTENSION <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> SCOLIOSIS <input type="checkbox"/> PELVIS <input type="checkbox"/> S.I. JOINTS <input type="checkbox"/> SACRUM/COCCYX <input type="checkbox"/> LUMBOSACRAL <p>SKELETAL SURVEY</p> <input type="checkbox"/> ARTHRITIC <input type="checkbox"/> METASTATIC <input type="checkbox"/> BONE AGE	<p>UPPER EXTREMETIES</p> <input type="checkbox"/> R L SHOULDER <input type="checkbox"/> R L CLAVICLE <input type="checkbox"/> R L AC JOINTS <input type="checkbox"/> R L SC JOINTS <input type="checkbox"/> R L SCAPULA <input type="checkbox"/> R L HUMERUS <input type="checkbox"/> R L ELBOW <input type="checkbox"/> R L FOREARM <input type="checkbox"/> R L WRIST <input type="checkbox"/> R L SCAPHOID <input type="checkbox"/> R L HAND <input type="checkbox"/> R L FINGERS NO ① ② ③ ④ ⑤	<p>LOWER EXTREMETIES</p> <input type="checkbox"/> R L HIPS <input type="checkbox"/> R L FEMUR <input type="checkbox"/> R L KNEE <input type="checkbox"/> R L TIBIA & FIBULA <input type="checkbox"/> R L ANKLE <input type="checkbox"/> R L FOOT <input type="checkbox"/> R L CALANEUS <input type="checkbox"/> R L TOES NO ① ② ③ ④ ⑤ OTHER: _____
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ULTRASOUND

<p>ABDOMEN</p> <input type="checkbox"/> ABDOMEN <input type="checkbox"/> ABDOMEN + PELVIC <input type="checkbox"/> ABDOMEN + PELVIC + TRANSVAGINAL <input type="checkbox"/> ABDOMEN + PELVIC LIMITED <input type="checkbox"/> ABDOMINAL WALL <input type="checkbox"/> ABDOMEN LIMITED <input type="checkbox"/> AAA SCREENING <input type="checkbox"/> KUB <input type="checkbox"/> RENAL <input type="checkbox"/> BLADDER <input type="checkbox"/> G.U. TRACT OTHER: _____	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> R L SHOULDER <input type="checkbox"/> R L BICEP <input type="checkbox"/> R L ELBOW <input type="checkbox"/> R L FOREARM <input type="checkbox"/> R L WRIST <input type="checkbox"/> R L HAND <input type="checkbox"/> R L HIP <input type="checkbox"/> R L KNEE <input type="checkbox"/> R L POPLITEAL FOSSA <input type="checkbox"/> R L HAMSTRING <input type="checkbox"/> R L ACHILLES TENDON <input type="checkbox"/> R L ANKLE <input type="checkbox"/> R L FOOT OTHER: _____	<p>OBSTETRICAL</p> <input type="checkbox"/> DATING < 16 WEEKS <input type="checkbox"/> NT 11-14 weeks (IPS/eFTS) <input type="checkbox"/> ANATOMIC 18-20 WEEKS <input type="checkbox"/> BIOPHYSICAL PROFILE (BPP) <input type="checkbox"/> LIMITED OB SCAN <input type="checkbox"/> FETAL GROWTH LMP: _____ <p>FEMALE PELVIC</p> <input type="checkbox"/> PELVIC <input type="checkbox"/> TRANSVAGINAL <input type="checkbox"/> PELVIC + TRANSVAGINAL <input type="checkbox"/> FOLLICULAR STUDIES	<p>MALE PELVIC</p> <input type="checkbox"/> PELVIC – TRANSABDOMINAL <input type="checkbox"/> PROSTATE + BLADDER <input type="checkbox"/> TRANSRECTAL / PROSTATE <p>SMALL PARTS</p> <input type="checkbox"/> THYROID <input type="checkbox"/> NECK <input type="checkbox"/> FACE <input type="checkbox"/> HERNIA <input type="checkbox"/> R L GROIN <input type="checkbox"/> TESTES/SCROTUM <input type="checkbox"/> CHEST WALL <input type="checkbox"/> SOFT TISSUE / LUMP <input type="checkbox"/> R L AXILLA OTHER: _____
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BONE MINERAL DENSITY

BASELINE (FIRST TIME)
 LOW RISK (EVERY 3 YEARS)
 HIGH RISK (ONCE A YEAR)
 PREVIOUS BMD DATE: _____

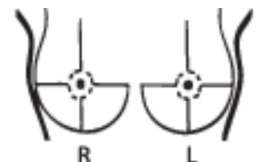
Please refer to the back of this form for preparation information or visit our website to learn more

BREAST IMAGING

ROUTINE SCREENING MAMMOGRAM (OBSP ACCREDITED)
 DIAGNOSTIC MAMMOGRAM (INDICATE AREA OF CONCERN)
 R L BILATERAL
 BREAST ULTRASOUND (INC. AXILLA)



ontario breast
screening program
a cancer care ontario program





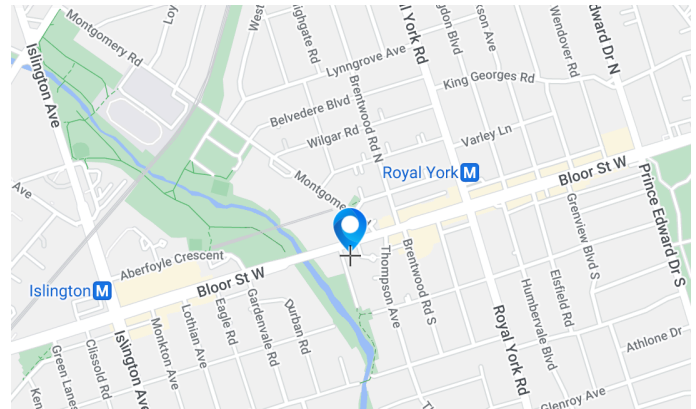
Hours: MON – FRI 8:30 AM to 6:00 PM
SATURDAY 8:30 AM to 3:00 PM
 3101 Bloor Street West Suite 103 Toronto, ON
Please bring this form & a valid OHIP card.

We take walk-ins for X-RAYS! For all other procedures, please visit our website now or call us below to book.

Website. www.hbmi.ca Tel. 416-239-3568

24 HRS NOTICE REQUIRED TO CANCEL.

Please read the following instructions pertaining to your procedure carefully. Failure to arrive on time and prepared may result in the cancellation/rebooking of your appointment.



ULTRASOUND	Preparation Instructions
ABDOMEN (Gall Bladder, Pancreas, Spleen, Liver, Kidneys, and Aorta)	If your appointment is in the morning, do not eat anything after midnight the night before. If your appointment is in the afternoon, for breakfast you may eat dry toast, black tea, black coffee, juice, up to 9 a.m. Nothing to eat or drink after that.
PELVIC TRANSVAGINAL (Uterus, Ovaries, and Bladder)	Finish drinking 5 glasses (1Litre) of water 1 hour before your appointment time. Do not empty your bladder. You must have a full bladder for this examination.
COMBINATION PELVIC AND ABDOMINAL	Finish drinking 5 glasses (1Litre) of water 1 hour before your appointment time. Do not empty your bladder. NO BREAKFAST on the morning of the examination. You must have a full bladder for this examination.
OBSTETRICAL (12 Weeks or less)	Finish drinking 5 glasses (1Litre) of water 1 hour before your appointment time. Do not empty your bladder. You must have a full bladder for this examination.
OBSTETRICAL (12 Weeks or more)	Finish drinking 3 glasses (750ml) of water a 1/2 hour before your appointment time. Do not empty your bladder. You must have a full bladder for this examination.
PROSTATE	Finish drinking 5 glasses (1Litre) of water 1 hour before your appointment time. Do not empty your bladder. You must have a full bladder for this examination.
TRANSRECTAL	Pick up a fleet enema at a pharmacy and use it according to the package instructions, 2 hours before your examination.
BONE DENSITY	Please wear a two piece outfit with no metal or zippers, if possible. Do not take calcium supplements 24 hours prior to appointment.
MAMMOGRAPHY	On the day of examination, do not use deodorant, antiperspirant or talcum powder under the arms or on the chest. Please wear a 2-piece outfit for your comfort.
HYSTEROSONOGRAM	May take anti-inflammatory medication (e.g. Tylenol, Advil, etc.) 1 hour before appointment. Bring sanitary pad/napkin. Your period must be finished 3 days before the exam.
ECHOCARDIOGRAM	No preparation required.
X-RAY	No preparation required. No appointment required, walk-ins are welcome!