



HBMI
HUMBER BAY
MEDICAL IMAGING

3101 Bloor Street West
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fax. 416-239-3569
email. help@hbmi.ca
website. www.hbmi.ca



CLINICAL INFORMATION

Date: _____

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

PATIENT INFORMATION

Name: _____ Phone #: _____
Address: _____ Postal Code: _____
City: _____ Health Card #: _____ VC: _____
D.O.B.: _____
I declare that I am not presently pregnant: _____

PHYSICIAN INFORMATION

Name: _____ Billing #: _____
Date: _____ Signature: _____
Phone: _____ Fax: _____
cc Physicians: _____
 STAT VERBAL
Contact: _____

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

<p>CHEST</p> <input type="checkbox"/> Chest PA & Lat <input type="checkbox"/> Chest PA <input type="checkbox"/> Sternum <input type="checkbox"/> R L Ribs & Chest PA <p>ABDOMEN</p> <input type="checkbox"/> KUB <input type="checkbox"/> Acute (3 Views) <p>Other: _____</p>	<p>HEAD & NECK</p> <input type="checkbox"/> Skull <input type="checkbox"/> Orbits <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> TM Joints <input type="checkbox"/> Adenoids <input type="checkbox"/> Neck (Soft Tissue) <p>Other: _____</p>	<p>SPINE & PELVIS</p> <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Lumbosacral Spine <input type="checkbox"/> Scoliosis Series <input type="checkbox"/> Pelvis <input type="checkbox"/> SI Joints <input type="checkbox"/> Sacrum & Coccyx <p>SKELETAL SURVEY</p> <input type="checkbox"/> Arthritic <input type="checkbox"/> Metastatic <input type="checkbox"/> Bone Age	<p>UPPER EXTREMITIES</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 <p>No. ① ② ③ ④ ⑤</p>	<p>LOWER EXTREMITIES</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 Calcaneus <input type="checkbox"/> R L Toes <p>No. ① ② ③ ④ ⑤</p>
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ULTRASOUND

<p>GENERAL</p> <input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen Limited <input type="checkbox"/> AAA Screening <input type="checkbox"/> Female Pelvic <input type="checkbox"/> Transvaginal <input type="checkbox"/> Limited <input type="checkbox"/> Male Pelvic / Prostate <input type="checkbox"/> Limited <input type="checkbox"/> Transrectal <input type="checkbox"/> KUB <p>Other: _____</p>	<p>SMALL PARTS</p> <input type="checkbox"/> Thyroid / Neck <input type="checkbox"/> Neck <input type="checkbox"/> R L Hernia / Groin <input type="checkbox"/> Testes / Scrotum <input type="checkbox"/> R L Soft Tissue / Lump <input type="checkbox"/> R L Abdominal Wall <p>Other: _____</p>	<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"/> With Doppler <input type="checkbox"/> Follow Up OB Scan <input type="checkbox"/> Twins <p>LMP: _____</p>	<p>VASCULAR</p> <input type="checkbox"/> R L Venous of Upper Limbs (DVT) <input type="checkbox"/> R L Venous of Lower Limbs (DVT) <input type="checkbox"/> R L Arterial of Upper Limbs <input type="checkbox"/> R L Arterial of Lower Limbs <input type="checkbox"/> R L Carotid Doppler <input type="checkbox"/> R L Renal Vascular <input type="checkbox"/> R L Portal Venous Doppler <input type="checkbox"/> R L Varicose Vein Assessment <input type="checkbox"/> R L Aorta & Iliac Arteries <p>Other: _____</p>
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BONE MINERAL DENSITY

Baseline
 2nd Test (3 Years After Baseline)
 Low Risk (Every 5 Years)
 High Risk (Every Year)
 Previous BMD Date: _____

BREAST IMAGING

OBSP / Routine Mammogram
 Diagnostic Mammogram (Indicate Area of Concern)
 R L
 Breast Ultrasound (Inc. Axilla)
 R L



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





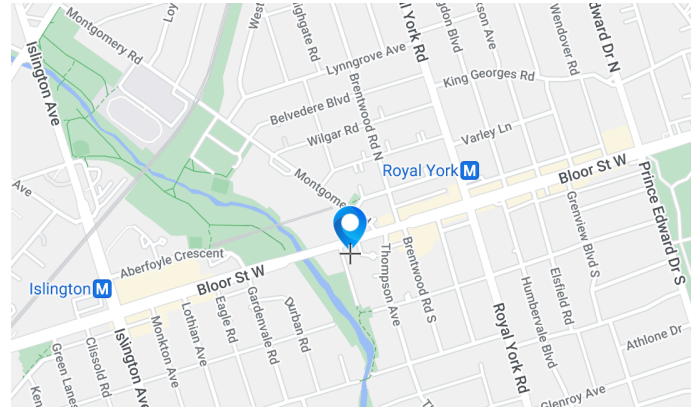
Hours: MON – FRI 8:30 AM to 6:00 PM
SATURDAY 8:30 AM to 4:00 PM
 3101 Bloor Street West Suite 103 Etobicoke, ON
Please bring this form & a valid OHIP card.

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 (1 Litre) 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 (1 Litre) 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 (1 Litre) 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 4 glasses (750 ml) 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 (1 Litre) 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.
X-RAY	No preparation required. No appointment required. Walk-ins are welcome!