Radiant Medical Imaging

Clinic Hours
Mon to Fri: 8 a.m. – 6 p.m.
Sat: 9 a.m. – 2 p.m.
Sun & Public Holidays closed
X-Ray Starts 10 a.m.

ADDRESS: 385 Silver Star Blvd - Suite 212, Scarborough, ON M1V 0E3 Tel: (416) 321-9243 Fax: (416) 321-1650

Please provide 24 hours notice for any cancellations. Please bring this requisition form and your valid Health Card.
Reports will be sent to referring physicians within 2-3 days. Urgent cases will be forwarded as soon as possible.

X-RAY*

(Starts 10:00 am Mon to Sat)

Abdomen
☐ Plain Film (KUB)
☐ Acute (3 views)

Head & Neck
☐ Skull
☐ Adenoids
☐ Soft Tissue of Neck
☐ Mastoids
☐ Facial Bones
☐ Nasal Bones
☐ Orbits
☐ Mandible
☐ T.M. Joints

Chest
☐ Chest
☐ Ribs & Chest P.A.
☐R ☐L
☐ Sternum
☐ Sterno-clavicular Joints
☐ Thoracic Inlet

Skeletal Survey
☐ Metastatic Series
☐ Arthritic Series

Pediatric
☐ Bone Age

Spine & Pelvis
☐ Cervical Spine
☐ Dorsal Spine
☐ Scoliosis Series
☐ Lumbo-sacral Spine
☐ L/S Spine, Pelvis & S.I. Joints
☐ Sacrum & Coccyx
☐ S.I. Joints
☐ Pelvis & Hips

Upper Extremities

R	L	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	A.C. Joint
☐	☐	Scapula
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Fingers

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Lower Extremities

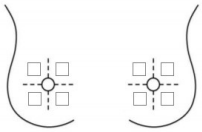
R	L	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tib & Fib
☐	☐	Ankle
☐	☐	Ankle incl. Stress Views
☐	☐	Foot
☐	☐	Os Calcis
☐	☐	Toes

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ **8. BREAST ULTRASOUND**

R	L	Bil.	Bil. Axilla
☐	☐	☐	☐

Right Left



ULTRASOUND

We accept walk-in patients

☐ **1A. Abdomen**
☐ G.B. & Biliary System
☐ Liver
☐ Pancreas
☐ Spleen
☐ Aorta & IVC
☐ Kidneys
☐ **1B. Liver Elastography** *(Non-OHIP)*
☐ **1C. Liver Steatosis (ATI)** *(Non-OHIP)*
☐ **2. Renals (Kidneys & Complete Pelvis)**
☐ **3. Female Pelvis** ☐ **Transvaginal**
☐ **4. Prostate and Urinary Bladder**
☐ Transrectal
☐ **5. Obstetrical**
☐ Early Dating
☐ NT Scan
☐ Routine 2nd Trimester
☐ Limited OB ☐ BPP

☐ **6. Musculoskeletal**

R	L	Bilateral	
☐	☐	☐	Shoulder
☐	☐	☐	Elbow
☐	☐	☐	Wrist
☐	☐	☐	Hip
☐	☐	☐	Knee
☐	☐	☐	Ankle/Heel
☐	☐	☐	Soft Tissue

☐ **7. Small Parts**
☐ Thyroid
☐ Neck
☐ Testes/Scrotum
☐ **8. Others** _____

X-Ray Pregnancy Release: I declare, to the best of my knowledge, that I am **NOT** presently pregnant. _____
☐ **Lead Shielding** _____ *Signature of Patient*

Clinical History:
_____
_____
_____

Referred By:
Physician Name: _____ Billing #: _____
Signature: _____ Date: _____
☐ **STAT** ☐ **VERBAL CC:** _____

Patient Info:
Last Name: _____
First Name: _____
Birthdate (DD/MM/YYYY): _____
Health Card No: _____ Version: _____

Address: _____
_____
Telephone: _____

Appointment:
Date: _____ Time: _____