



**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	HEAD & NECK	UPPER EXTREMITIES	LOWER EXTREMITIES
<input type="checkbox"/> Chest <input type="checkbox"/> Ribs L R <input type="checkbox"/> Sternum <input type="checkbox"/> KUB <input type="checkbox"/> Abdomen series <b>SPINE</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum & Coccyx <input type="checkbox"/> S.I. joints <input type="checkbox"/> Scoliosis series	<input type="checkbox"/> Skull <input type="checkbox"/> Facial bones <input type="checkbox"/> Nose <input type="checkbox"/> Neck soft tissues <input type="checkbox"/> Mandible <input type="checkbox"/> Orbits <b>SKELETAL SURVEY &amp; BONE AGE</b> <input type="checkbox"/> Metastatic survey <input type="checkbox"/> Arthritic survey <input type="checkbox"/> Metabolic survey <input type="checkbox"/> Bone age	<input type="checkbox"/> Acromioclavicular joints <input type="checkbox"/> Sternoclavicular joints <input type="checkbox"/> Clavicle L R <input type="checkbox"/> Scapula L R <input type="checkbox"/> Shoulder L R <input type="checkbox"/> Humerus L R <input type="checkbox"/> Elbow L R <input type="checkbox"/> Forearm L R <input type="checkbox"/> Wrist L R <input type="checkbox"/> Scaphoid L R <input type="checkbox"/> Hand L R <input type="checkbox"/> Finger L R 1 2 3 4 5	<input type="checkbox"/> Pelvis <input type="checkbox"/> Hip L R <input type="checkbox"/> Femur L R <input type="checkbox"/> Knee L R <input type="checkbox"/> Patella L R <input type="checkbox"/> Tib fib L R <input type="checkbox"/> Ankle L R <input type="checkbox"/> Foot L R <input type="checkbox"/> Heel L R <input type="checkbox"/> Toe L R 1 2 3 4 5 <input type="checkbox"/> Weight bearing views <b>SCANOGRAM</b> <input type="checkbox"/> Standing A C E <input type="checkbox"/> Lying down

**MAMMOGRAPHY A C D E G with appointment**

Diagnostic  Tomosynthesis  
 Screening\*  
 \* RAMQ covers only 1 exam per year  
**A C D E**

**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 \_\_\_\_\_  Cervical spine  
 Brain  Thoracic spine  
 Sella turcica & Pituitary  Lumbar spine  
 I.A.C. & Mastoids  S.I. Joints  
 Orbits  Sacrum-coccyx  
 Sinuses  Chest  
 Facial bones  Abdomen & Pelvis  
 T.M. Joints  Enterography  
 Neck (ENT)  Virtual Colonoscopy  
 \_\_\_\_\_  Dentascan \_\_\_\_\_  
 Cardiac Scoring  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 F with appointment**

Brain  Angiography \_\_\_\_\_  
 Pituitary gland  Cervical spine  Abominal  
 I.A.C. / mastoids  Thoracic spine  Pelvis  
 Facial bones  Lumbar spine  Prostate  
 Orbits  S.I. Joints  Iron/fat quantific.  
 T.M. Joints  Sacrum-coccyx  Defecography  
 Sinuses  Brachial Plexus  Enterography  
 Neck (ENT)  Lumbar Plexus  Breasts  
 Salivary gland  
 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, Roloids 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.

**BIARIUM 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 <input type="checkbox"/>	No <input type="checkbox"/>	Joint prosthesis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stent	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing aid	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aneurysm clip	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Denture or teeth braces	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ocular or cochlear implant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Metal plate, screw, nail, staples or sutures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Breast implant or marker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Shrapnel, bullet, gunshot	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Magnetic penile implant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	VP shunt	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Insulin pump, Blood glucose sensor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	IVC filter (Birdnest)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neuro or biostimulator	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cotrel or Harrington rod	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nicotine or medicated patch	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Metallic ocular foreign body	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tinted contact lenses	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tattoo, piercing or permanent makeup	Yes <input type="checkbox"/>	No <input type="checkbox"/>

- Are you:**  Claustrophobic (if yes, have an Ativan prescription)  
 Allergic (if yes, specify) \_\_\_\_\_  
 Pregnant (if yes, how many weeks) \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### WESTMOUNT SQUARE A

1 Westmount Square, suite C210  
Westmount (QC) H3Z 2P9  
Tel.: 514-939-9764  
Fax: 514-939-9363  
E-mail: [info.ws@radimed.ca](mailto:info.ws@radimed.ca)

### SAINT-LAURENT B

6363 Transcanadienne, bureau 135  
Ville Saint-Laurent (QC) H4T 1Z9  
Tel.: 514-747-5995  
Fax: 514-338-6996  
E-mail: [info.sl@radimed.ca](mailto:info.sl@radimed.ca)

### WEST-ISLAND C

215 Frobisher  
Pointe-Claire (QC) H9R 4R9  
Tel.: 514-697-9940  
Fax: 514-697-3711  
Fax: 514-697-8854 – MRI only  
E-mail: [info.wi@radimed.ca](mailto:info.wi@radimed.ca)

### VAUDREUIL-DORION D

600 Boulevard Harwood  
Vaudreuil-Dorion (QC) J7V 6A3  
Tel.: 450-218-6111  
Fax: 450-218-7111  
E-mail: [info.vd@radimed.ca](mailto:info.vd@radimed.ca)

### VALLEYFIELD E

616 Chemin Larocque, suite 210  
Salaberry-de-Valleyfield (QC) J6T 4C5  
Tel.: 450-371-6442  
Fax: 450-371-5062  
E-mail: [info.vf@radimed.ca](mailto:info.vf@radimed.ca)

### TROIS-LACS F

2555 Dutrisac, suite 105  
Vaudreuil-Dorion (QC) J7V 7E6  
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### PIERREFONDS G

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