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 819-373-1603
 TOLL-FREE
 1-866-916-6622

PHYSICIAN

ADDRESS OR STAMP OF
 ATTENDING PHYSICIAN

REPORT

French English

Signature of attending physician required _____ Licence _____ Date _____

PATIENT

Name: _____
 D.O.B.: _____ / _____ / _____
 Tel.: _____
 Email: _____

CNESST SAAQ Pregnant Yes No

CLINICAL INFORMATION (MANDATORY)

Tech.: _____ No. X-rays: _____ Fluoro.: _____ Min. _____ Sec. _____

The numbers indicate that your examination requires preparation. Please read the instructions for the corresponding number on the back of this sheet.

X-RAY (without appointment)

CHEST / RIBS / ABDOMEN

- Chest
- Thorax R L
- Sternum
- Abdomen

SPECIAL EXAMINATIONS

- Arthritic series
- Metastatic series
- Other (specify): _____

HEAD / NECK

- Cranium
- Facial bones
- Mandible (lower jaw)
- Cavum
- Neck soft tissue
- Nasal bones
- Orbits
- Mastoid bones
- T.M.J.

SPINE / PELVIS

- Cervical
- Thoracic
- Lumbosacral
- Sacroiliac joints
- Pelvis R L
- Hip R L
- Sacrum
- Coccyx
- Scoliosis series

UPPER EXTREMITIES

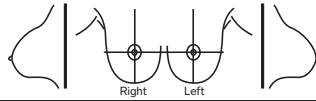
- Acromioclavicular joints
- Sternoclavicular joints
- Bone age
- Clavicle R L
- Scapula R L
- Shoulder R L
- Humerus R L
- Elbow R L
- Forearm R L
- Wrist R L
- Hand R L
- Finger R L

LOWER EXTREMITIES

- Femur R L
- Knee R L
- Leg R L
- Ankle R L
- Foot R L
- Toe R L
- Specify: _____
- Orthodiagraphy (lower extremity measurements)
- Specify: _____

MAMMOGRAM / BONE DENSITOMETRY (with appointment)

- Diagnostic (clinical information is essential) ③
- Magnified / additional views ③ Right Left
- Screening ages 50 to 74 (PQDCS) ③
- Screening ages 35 to 49, age 75 and over ③



- Bone densitometry ④ (including dorsolumbar spine profile)
 Date of last examination: YYYY / MM / DD
- Lipodensitometry** ④A

DIGESTIVE RADIOLOGY (with appointment)

- Esophagus ① Pharynx + esophagus (swallowing) ①

ULTRASOUND AND FLUOROSCOPY MUSCULOSKELETAL DIAGNOSIS AND TREATMENT (with appointment)

MUSCULOSKELETAL ULTRASOUND

- Diagnostic ultrasound only - Region: _____
- Diagnostic ultrasound and cortisone injection - Region: _____
- Cyst puncture or aspiration - Region: _____
- Calcific lavage - Region: _____
- Other: _____

MUSCULOSKELETAL FLUOROSCOPY

- Arthrography and cortisone injection - Region: _____
- Arthrography and viscosupplement injection* - Region: _____
- Distension arthrography of the shoulder Right Left
 Repeat 3 X as required
- Bursography - Region: _____
- Facet block(s) ② - Level(s) : _____

* Patients must bring their medication.

ULTRASOUND (with appointment)

- Abdominal ⑤ Thyroid
- Transvesical pelvic (and endovaginal if necessary) ⑥A Cardiac*
- Spinal Surface

OBSTETRICAL (with appointment)

- First trimester pelvic OB exam (fetal heart and dating) ⑥C
- Prenatal screening (nuchal translucency)*** ⑥C
- Third-trimester obstetric ultrasound (26 to 40 weeks)*** ⑥B

DOPPLER (with appointment)

VENOUS

- Upper limbs (check for thrombosis (phlebitis)) R L
- Lower limbs (check for thrombosis (phlebitis)) R L
- Lower limbs (venous insufficiency assessment)**** R L

ARTERIAL

- Aneurysm screening ABI****
- Upper limbs**** Check for thoracic outlet****
- Lower limbs (including ABI)****

OTHERS

- Carotid
- Renal

COMPUTED TOMOGRAPHY (CT SCAN) ⑦ (with appointment)**

- Cerebral Thorax Abdomen Cervical spine Pudendal nerve block, piriform
- I.A.C. Calcium score ⑦A Pelvic Thoracic spine Foraminal block ②: 1 root 2 roots
- Orbits Lungs: screening for pulmonary nodules Enterography Angioscan Thorax
- Sinus Virtual colonoscopy Osteoarticular Abdominal
- Mastoid bones Arthro-scan _____ Carotid
- Neck soft tissue
- Other (specify) _____

Creatinine ⑨ : Ref. value: _____ Date: _____

MAGNETIC RESONANCE (MRI) ⑧ (with appointment)**

- Cerebral Facial bones Thorax Cervical spine MR-angiography
- I.A.C. T.M.J. Abdomen Thoracic spine Shoulder Hip Cerebral Abdominal
- Orbits Neck MR cholangiography Lumbar spine Elbow Knee MR-arthrogram _____
- Brachial plexus Prostate Total spine Wrist Ankle MR-enterography _____
- Other (specify): _____

Fees apply for this test because it is interpreted by a cardiologist, not a radiologist. / *Fees apply for these tests.

Fees apply for this test because it is interpreted by a gynecologist, not a radiologist. / * Fees apply for this test because it is interpreted by an internist, not a radiologist.

Magnetic Resonance (MRI) - Important questionnaire to be completed by the physician and the patient

Last name: _____ First name: _____ D.O.B.: _____

The patient has:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	a cardiac pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	brain, neck, aorta metal clips (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	metallic implants or other devices (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	prostheses: auditory, ocular, dental, capillary, joint or other (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	rods, plates, nails or screws as a result of a fracture or surgery (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	body piercing
<input type="checkbox"/>	<input type="checkbox"/>	tattoos (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	magnetic false eyelashes
<input type="checkbox"/>	<input type="checkbox"/>	other factors (specify) _____

The patient:

<input type="checkbox"/>	<input type="checkbox"/>	has undergone surgery within the last 12 weeks
<input type="checkbox"/>	<input type="checkbox"/>	is claustrophobic (if so, plan medication)
<input type="checkbox"/>	<input type="checkbox"/>	is pregnant. No. of weeks: _____
<input type="checkbox"/>	<input type="checkbox"/>	has allergies (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	has glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	has had a prior eye injury involving a metallic foreign body (specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	has already had an MRI (specify) _____

Patient's weight: _____ Patient's height: _____

I have completed the above questionnaire with my physician. I confirm that the information provided is accurate and I agree to undergo the magnetic resonance (MRI) examination.

Date: _____ Physician's signature: _____ Patient's signature: _____

Please bring this form and your health insurance card with you on the day of the examination. Check the expiration date of your health insurance card.
If you are or think you might be pregnant, please inform the technologist BEFORE your examination.

PREPARATION INSTRUCTIONS – For patients aged 12 years or older

For children age 12 and under: Please follow the preparation instructions on our website: imagix.biron.com/en

1 NO PREPARATION REQUIRED

2 INJECTION

For your safety, you must be accompanied by someone who will drive you back after getting your epidural blocks, foraminal blocks or cervical facet blocks and injections at the level of the ischia.

3 MAMMOGRAM

Do not use any deodorant, perfume, powder or body lotion the day of the examination. If your previous mammogram was performed elsewhere, bring both the CD and report with you for comparison purposes.

4 BONE DENSITOMETRY

The patient must not have undergone any examination with barium or nuclear medicine for at least 14 days before his/her appointment with us. **DO NOT TAKE CALCIUM SUPPLEMENTS OR VITAMINS FOR 48 HOURS BEFORE THE DAY OF THE EXAMINATION.**

4A LIPODENSITOMETRY

No examination with barium or in nuclear medicine must have been performed at least 14 days prior to your appointment. **DO NOT TAKE ANY CALCIUM OR VITAMIN SUPPLEMENTS 48 HOURS BEFORE THE DAY OF THE EXAMINATION. YOU MUST FAST 4 HOURS BEFORE THE EXAMINATION.**

5 ABDOMINAL ULTRASOUND

- Fasting 4 to 6 hours before the exam.
- Do not chew gum.

YOU CAN TAKE YOUR MEDICATION, BUT WITH AS LITTLE WATER AS POSSIBLE.

5A - Abdominal and pelvic ultrasound

- Fasting 4 to 6 hours before the exam.
- Do not chew gum.
- Have finished drinking 4 to 8 ounce (960 ml) glasses of water 75 minutes before the examination and do not urinate.

6 PELVIC ULTRASOUNDS

You must have finished drinking four 8-ounce (960 mL) glasses of water or juice 75 minutes before your examination and **you must not urinate.**

6 A - Pelvic ultrasound: Be sure to have a FULL BLADDER when you arrive for your appointment. You must have finished drinking four 8-ounce (960 mL) glasses of water or juice 75 minutes before your examination and **you must not urinate.**

6 B - Pelvic obstetric third trimester: no preparation required. Do not urinate before the examination.

6 C - Pelvic obstetric ultrasound: For first trimester and prenatal screening (nuchal translucency): Drink two 8-ounce glasses of water (480 mL) or juice **one hour before the examination and do not urinate.**

7 CT SCAN

A light meal (e.g. toast with jam, cereal or soup) is permitted before any type of CT scan. If it is a CT scan with contrast injection, please indicate if the patient is at risk of kidney failure (age, diabetes, etc.).

Creatinine: Ref. value: _____ Date: _____

VIRTUAL COLONOSCOPY: Please follow the preparation on our website.*

7A – Calcium score: Avoid exercising and consuming caffeine in the four hours before the exam.

8 MAGNETIC RESONANCE (MRI)

For abdominal examinations, MR cholangiographies, MR enterographies and pelvic MRIs, you must fast (no food or drink) for six (6) hours before your examination.

9 CREATININE

The creatinine clearance test can be performed on-site the same day.

YOU MAY TAKE YOUR MEDICATION WITH A MINIMUM AMOUNT OF WATER UP TO TWO HOURS BEFORE YOUR EXAMINATION.

* You can find the specific preparation for your examination on our website: imagix.biron.com/en

WHERE TO FIND US

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Radiologie Blainville
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Radiologie Chomedey
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Radiologie Sainte-Dorothée
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H7X 3S5

Radiologie 440

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H1K 2T2

Radiologie Laënnec

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H3P 3H5

Radiologie Saint-Laurent

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H4R 0B7

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Radiologie Brossard
2340 Lapinière Blvd., Suite A
J4Z 2K7

Radiologie Châteauguay

230 Brisebois Blvd., Suite 201
J6K 4W8

Radiologie DIX30 (partnership)

9090 Leduc Blvd., Suite 190
J4Y 0E2

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