Imagix B

WEBSITE
imagix.biron.com/en

MONTREAL
514-866-6622

TROIS-RIVIÈRES
819-373-1603

TOLL-FREE
1-866-916-6622

PHYSICIAN

ADDRESS OR STAMP OF ATTENDING PHYSICIAN

Signature of attending physician required | Licence | Date

REPORT
❑ French ❑ English

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
❑ Hip ❑ R ❑ L
❑ Sacrum
❑ Coccyx
❑ Scoliosis series

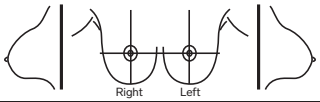
UPPER EXTREMITIES
❑ Acromioclavicular joints
❑ Sternoclavicular joints
❑ Bone age
❑ Clavicle ❑ R ❑ L
❑ Scapula ❑ R ❑ L
❑ Shoulder ❑ R ❑ L
❑ Humerus ❑ R ❑ L
❑ Elbow ❑ R ❑ L
❑ Forearm ❑ R ❑ L
❑ Wrist ❑ R ❑ L
❑ Hand ❑ R ❑ L
❑ Finger ❑ R ❑ L

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) ❸
❑ Magnified / additional views ❸ ❑ Right ❑ Left
❑ Screening ages 50 to 74 (PQDCS) ❸
❑ Screening ages 35 to 49, age 75 and over ❸



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

DIGESTIVE RADIOLOGY (with appointment)

❑ Esophagus ❶ ❑ Pharynx + esophagus (swallowing) ❶

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) ❷ - Level(s) : _____

* Patients must bring their medication.

ULTRASOUND (with appointment)

❑ Abdominal ❺
❑ Transvesical pelvic (and endovaginal if necessary) ❻A
❑ Spinal
❑ Thyroid
❑ Cardiac*
❑ Surface
❑ Breast
❑ Testicular

OBSTETRICAL (with appointment)

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

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
❑ Upper limbs****
❑ Lower limbs (including ABI)****
❑ ABI****
❑ Check for thoracic outlet****

OTHERS
❑ Carotid
❑ Renal

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

❑ Cerebral
❑ I.A.C.
❑ Orbits
❑ Sinus
❑ Mastoid bones
❑ Neck soft tissue
❑ Other (specify) _____

❑ Thorax
❑ Calcium score ❼A
❑ Lungs: screening for pulmonary nodules

❑ Abdomen
❑ Pelvic
❑ Enterography
❑ Virtual colonoscopy

❑ Cervical spine
❑ Thoracic spine
❑ Lumbar spine
❑ Osteoarticular
❑ Arthro-scan _____

❑ Pudendal nerve block, piriform
❑ Foraminal block ❷ : ❑ 1 root ❑ 2 roots
❑ Angioscan ❑ Thorax ❑ Abdominal ❑ Carotid

Creatinine ❾ : Ref. value: _____ Date: _____

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

❑ Cerebral
❑ I.A.C.
❑ Orbits
❑ Facial bones
❑ T.M.J.
❑ Neck
❑ Brachial plexus
❑ Thorax
❑ Abdomen
❑ MR cholangiography
❑ Prostate
❑ Cervical spine
❑ Thoracic spine
❑ Lumbar spine
❑ Total spine

	R	L		R	L
Shoulder	❑	❑	Hip	❑	❑
Elbow	❑	❑	Knee	❑	❑
Wrist	❑	❑	Ankle	❑	❑

❑ MR-angiography
❑ Cerebral ❑ Abdominal
❑ MR-arthrogram _____
❑ 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.: _____

	Yes	No	
The patient has:	❑	❑	a cardiac pacemaker
	❑	❑	brain, neck, aorta metal clips (specify) _____
	❑	❑	metallic implants or other devices (specify) _____
	❑	❑	prostheses: auditory, ocular, dental, capillary, joint or other (specify) _____
	❑	❑	rods, plates, nails or screws as a result of a fracture or surgery (specify) _____
	❑	❑	body piercing
	❑	❑	tattoos (specify) _____
	❑	❑	magnetic false eyelashes
	❑	❑	other factors (specify) _____
The patient:	❑	❑	has undergone surgery within the last 12 weeks
	❑	❑	is claustrophobic (if so, plan medication)
	❑	❑	is pregnant. No. of weeks: _____
	❑	❑	has allergies (specify) _____
	❑	❑	has glaucoma
	❑	❑	has had a prior eye injury involving a metallic foreign body (specify) _____
	❑	❑	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**

❶ NO PREPARATION REQUIRED

❷ 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.

❸ 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.

❹ 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.**

❹A 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.

❺ 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.

❺A - 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.

❻ 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**.

❻ 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.**

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

❻ 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.**

❼ 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.*

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

❽ 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.

❾ 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

GRANBY

Radiologie Granby
66 Court Street, Suite 100
J2G 4Y5

LAVAL - LAURENTIDES

Radiologie Blainville
519 Curé-Labelle Blvd.,
J7C 2H6

Radiologie Chomedey
610 Curé-Labelle Blvd.,
H7V 2T7

Radiologie Sainte-Dorothée
3 Samson Blvd., Suite A
H7X 3S5

Radiologie 440
4650 Desserte S., Highway 440,
Suite 135
H7T 2Z8

Radiologie Saint-Eustache
375 Mathers Avenue, Suite 210
J7P 4C1

Radiologie Sainte-Thérèse
233 Turgeon Street, Suite 104
J7E 3J8

MONTREAL

Radiologie Montréal-Nord
5636 Henri-Bourassa Blvd. East,
H1K 2T2

Radiologie Laënnec
1100 Beaumont Avenue, Suite 104
H3P 3H5

Radiologie Saint-Laurent
1605 Marcel-Laurin Blvd., Suite 290
H4R 0B7

MONTÉRÉGIE

Radiologie Boucherville
600 Fort St-Louis, Suite 202
J4B 1S7

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

TROIS-RIVIÈRES

Radiologie des Récollets
1900 des Récollets Blvd., Suite 185
G8Z 4K4

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Book an appointment online : **imagix.biron.com** | Fax: **514 738-1883**