Imagix B

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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.: Nb. 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)

LUNGS / CHEST / RIBS / ABDOMEN
❑ Lungs
❑ Thorax ❑ R ❑ L
❑ Sternum
❑ Abdomen

SPECIAL EXAMINATIONS
❑ Arthritic serie
❑ Metastatic serie
❑ Other; specify ____

HEAD / NECK
❑ Cranium
❑ Sinuses
❑ Facial bones
❑ Mandible (lower jawbone)
❑ Cavum (soft tissues of neck)
❑ Nasal bones
❑ Orbits
❑ Mastoid bones
❑ T.M.J.

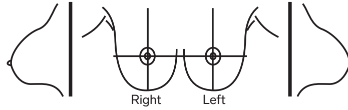
SPINE / PELVIS
❑ Cervical
❑ Thoracic
❑ Lumbosacral
❑ Sacroiliac joints
❑ Pelvis
❑ Hip ❑ R ❑ L
❑ Sacrum
❑ Coccyx
❑ Scoliosis series

UPPER EXTERMITIES
❑ 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 ____

MAMMOGRAPHY / BONE DENSITOMETRY (with appointment)

❑ Diagnostic (clinical information is essential) ❹
❑ Enlargements/Complementary Images ❹ ❑ Right ❑ Left
❑ Screening ages 50 to 69 (PQDCS) ❹
❑ Screening ages 35 to 49, age 70 and over ❹



❑ Bone densitometry ❺
(including thoracolumbar spine profile)
Date of last examination: YYYY / MM / DD

FLUOROSCOPY (with appointment)

DISGESTIVE RADIOLOGY
❑ Esophagus ❶
❑ Barium meal ❶
❑ Pharynx + Esophagus (swallowing) ❶
❑ Barium enema ❷
❑ Small bowel series ❶

INFILTRATION MUSCULOSKELETAL
❑ Arthrography therapeutic (injection) ❸ ❑ R ❑ L Specify: ____
❑ Distension arthrogram ❸ ❑ R ❑ L
❑ Facet block ❸ ❑ R ❑ L Level (s): ____

ULTRASOUND (with appointment)

❑ Abdominal ❻
❑ Transvesical pelvic (and endovaginal if necessary) ❼ A
❑ Spinal
❑ Surface
❑ Thyroid
❑ Cardiac*
❑ Infiltration
❑ Musculoskeletal (specify): ____
❑ Breast
❑ Testicular

OBSTETRICAL (with appointment)

❑ First trimester OB exam (foetal heart and dating) ❼ C
❑ Second trimester OB exam ❼
❑ Third trimester OB exam ❼
❑ Prenatal screening (nuchal translucency)*** ❼ B

DOPPLER (with appointment)

VENOUS
❑ Detection of thrombosis (phlebitis) ❑ R ❑ L
❑ Upper extremities ❑ Lower extremities

ARTERIAL
❑ Aneurysm screening

OTHERS
❑ Carotid
❑ Renal

CT-Scan ❽ (with appointment)**

❑ Cranium
❑ Orbits
❑ I.A.C.
❑ Sinuses
❑ Mastoid bones
❑ Soft tissues of neck
❑ Chest
❑ Cardiac calcium scoring
❑ Screening for lung nodules
❑ Abdomen
❑ Pelvic
❑ Abdomen and pelvic
❑ Visceral fat evaluation
❑ Virtual coloscopy
❑ Spine ____
❑ Musculoskeletal ____
❑ Angioscan ❑ Thorax ❑ Abdominal
❑ Arthro-CT

Creatinine ❿ : Ref. value: ____ Date : ____

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

❑ Cerebral
❑ I.A.C.
❑ Orbits
❑ Facial bones
❑ T.M.J.
❑ Neck
❑ Brachial plexus
❑ Thorax
❑ Breasts
❑ Abdomen
❑ Pelvic
❑ Prostate
❑ Cervical
❑ Thoracic spine
❑ Lumbar spine
❑ Total spine
❑ Musculoskeletal
Shouler R ❑ L ❑ Hip R ❑ L ❑
Elbow R ❑ L ❑ Knee R ❑ L ❑
____
❑ Angio-resonance
❑ Cerebral ❑ Abdominal
❑ MRCP
❑ Arthro-MRI

❑ Other (specified): ____ Creatinine ❿ : Ref. value: ____ Date : ____

*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.

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
	❑	❑	cerebral, neck, or aorta metallic clip(s); specify ____________
	❑	❑	metallic implant(s) or other devices; specify ____________
	❑	❑	prosthesis(-es): auditory, ocular, dental, capillary, joint, or other; specify ____________
	❑	❑	rod(s), plate(s), nail(s), screw(s), as a result of a fracture or surgery; specify ____________
	❑	❑	body piercing
	❑	❑	tattoo(s)
	❑	❑	magnetic false eyelashes
	❑	❑	other(s); 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 12 years old and up

❶ ESOPHAGUS – BARIUM MEAL and/or SMALL BOWEL
No solids or liquids should be ingested after 8 p.m. the night before the exam, but patients may drink water until midnight. For patients who have an appointment in the afternoon, no solid food should be absorbed 8 hours before the exam. Do not smoke or chew gum. Examination of the small intestine can last anywhere from 30 minutes to 3 hours.

❷ BARIUM ENEMA
At least 2 days before the exam, purchase the product "Pico-Salax – 2 sachets" at the drugstore. Follow the preparation instructions found on our website.*

❸ 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. **On the day of the injection, please provide the CD for any previous relevant examinations done in the past six months, along with a copy of the reports.**

❹ 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 film and report with you, for comparison purposes.

❺ 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.**

❻ ABDOMINAL ULTRASOUND
If you have a morning appointment, you must not have any **solid or liquid food after midnight**. If you have an afternoon appointment, **you must not have any solid or liquid food during the 4 to 6 hours before the test**. Most importantly, **do not eat anything fatty on the morning of your exam**. Also, do not chew gum as this will cause you to inhale air and will result in a poorer quality test. **(YOU CAN TAKE YOUR MEDICATION, BUT WITH AS LITTLE WATER AS POSSIBLE.)**

❼ ULTRASOUNDS
You must have finished drinking 4 glasses of 8 ounces (960ml) of water or juice 75 minutes before your examination and **you must not urinate**.

❼ A - Pelvic ultrasound: Be sure to have a FULL BLADDER when you arrive for your appointment. You must have finished drinking 4 glasses of 8 ounces (960ml) of water or juice 75 minutes before your examination and **you must not urinate.**

❼ B - Prenatal screening (nuchal translucency): No preparation is required, but **do not** urinate before the test.

❼ C - Obstetrical ultrasound: During the first trimester and at **18-20 weeks:** drink 2 glasses (8 ounces each) of water or juice 1 hour before the test and **do not urinate. At 21 weeks or more:** drink one glass (8 ounces) of water or juice 1 hour before the test and **do not urinate.**

❽ CT-SCAN (Computerized Axial Tomography)
Unless otherwise instructed, the patient must be fasting for at least 4 hours and should bring copies of relevant previous radiologic exams (i.e., skull, spine, renal pelvis and ureter (pyelography), musculoskeletal system, etc.). **Scan with injection of contrast media:** Please indicate if the patient is at risk of kidney failure (age, diabetes, etc.).
Creatinine: Ref. Level: ____________ **Date:** ____________
VIRTUAL COLONOSCOPY: Follow the preparation instructions on our website.*

❾ MAGNETIC RESONANCE (MRI)
Please bring the CD of any examinations you have undergone in the past 3 months, including a copy of the report. **For Abdominal and Pelvic exams and Magnetic Resonance Cholangiography, the patient must be fasting (no food and drink) for 6 hours before the exam.**

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

YOU CAN CONTINUE TAKING YOUR MEDICATION, WITH ONLY A LITTLE WATER, UP UNTIL 2 HOURS BEFORE THE EXAMINATION.

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

WHERE TO FIND US

GRANBY

Radiologie Granby
66 Court Street, office 100
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LAVAL - LAURENTIDES

Radiologie Blainville
519 Curé-Labelle blvd.
J7C 2H6

Radiologie Chomedey
610 Curé-Labelle blvd.
H7V 2T7

Radiologie Sainte-Dorothée
3 Samson blvd., office A
H7X 3S5

Radiologie Saint-Eustache
75 Grignon Street, office 18
J7P 4J2

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

MONTREAL

Radiologie Cabrini
5700 Saint-Zotique East Street, office 101
H1T 1P7

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

Radiologie Laënnec
1100 Beaumont Avenue, office 104
H3P 3H5

Radiologie Saint-Laurent
1605 Marcel-Laurin blvd., office 290
H4R 0B7

MONTÉRÉGIE

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

Radiologie Brossard
2340 Lapinière blvd., office A
J4Z 2K7

Radiologie Châteauguay
230 Brisebois blvd., office 201
J6K 4W8

Radiologie DIX30 (partenariat)
9090 Leduc blvd., office 190
J4Y 0E2

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