

## 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.: \_\_\_\_\_ 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  R  L
- Hip  R  L
- Sacrum
- Coccyx
- Scoliosis series

### UPPER EXTERMITIES

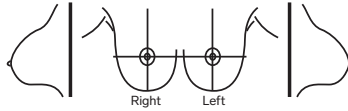
- Acromioclavicular joints
- Sternoclavicular joints
- Bone age
- Clavicle  R  L
- Scapula  R  L
- Shoulder  R  L
- Humerus  R  L
- Elbow  R  L
- Forearm  R  L
- Wrist  R  L
- Hand  R  L
- Finger  R  L

### LOWER EXTERMITIES

- 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) ④
- Enlargements/Complementary Images ④  Right  Left
- Screening ages 50 to 69 (PQDCS) ④
- Screening ages 35 to 49, age 70 and over ④



- Bone densitometry ⑤ (including thoracolumbar spine profile)
- Date of last examination: YYYY / MM / DD

## FLUOROSCOPY (with appointment)

### DISGESTIVE RADIOLOGY

- Esophagus ①
- Barium meal ①
- Pharynx + Esophagus (swallowing) ①
- Barium enema ②
- Small bowel series ①

### INFILTRATION MUSCULOSKELETAL

- Arthrography therapeutic (injection) ③
- Distension arthrogram ③
- Facet block ③
- R  L Specify: \_\_\_\_\_
- R  L
- R  L Level (s): \_\_\_\_\_

## ULTRASOUND (with appointment)

- Abdominal ⑥
- Transvesical pelvic (and endovaginal if necessary) ⑦ A
- Spinal
- Surface
- Thyroid
- Cardiac\*
- Infiltration
- Musculoskeletal (specify): \_\_\_\_\_
- Breast
- Testicular

## OBSTETRICAL (with appointment)

- First trimester OB exam (foetal heart and dating) ⑦ C
- Second trimester OB exam ⑦
- Third trimester OB exam ⑦
- Prenatal screening (nuchal translucency) ⑦ B

## DOPPLER (with appointment)

### VENOUS

- Detection of thrombosis (phlebitis)  R  L
- Upper extremities  Lower extremities

### ARTERIAL

- Aneurysm screening

### OTHERS

- Carotid
- Renal

## CT-Scan ⑧ (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 colonoscopy
- Spine \_\_\_\_\_
- Musculoskeletal \_\_\_\_\_
- Angioscan
- Thorax
- Abdominal
- Arthro-CT

Creatinine ⑩ : Ref. value: \_\_\_\_\_ Date : \_\_\_\_\_

## MAGNETIC RESONANCE (MRI) ⑨ (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
- Shoulder  R  L  Hip  R  L  Elbow  R  L  Knee  R  L
- Angio-resonance
- Cerebral
- Abdominal
- MRCP
- Arthro-MRI

Other (specified): \_\_\_\_\_ Creatinine ⑩ : Ref. value: \_\_\_\_\_ Date : \_\_\_\_\_

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

\*\*Fees apply for these tests.

# 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"/>	cerebral, neck, or aorta metallic clip(s); specify _____
<input type="checkbox"/>	<input type="checkbox"/>	metallic implant(s) or other devices; specify _____
<input type="checkbox"/>	<input type="checkbox"/>	prosthesis(-es): auditory, ocular, dental, capillary, joint, or other; specify _____
<input type="checkbox"/>	<input type="checkbox"/>	rod(s), plate(s), nail(s), screw(s), as a result of a fracture or surgery; specify _____
<input type="checkbox"/>	<input type="checkbox"/>	body piercing
<input type="checkbox"/>	<input type="checkbox"/>	tattoo(s)
<input type="checkbox"/>	<input type="checkbox"/>	other(s); 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 12 years old and up

**① 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.

**② 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.\*

**③ 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.

**④ 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.

**⑤ 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.**

**⑥ 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.)

**⑦ ULTRASOUNDS**  
**⑦ 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.

**⑦ B - Prenatal screening (nuchal translucency):** No preparation is required, but do not urinate before the test.

**⑦ 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.

**⑧ 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.\*

**⑨ 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.

**⑩ 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](http://biron.com/en/medical-imaging).

## WHERE TO FIND US

**GRANBY**  
Radiologie Granby  
66 Court Street, office 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., 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

**TROIS-RIVIÈRES**  
Radiologie des Récollets  
1900 des Récollets blvd., office 185  
G8Z 4K4  
T 819 373-1603 F 819 373-1604

Fax: 514 738-1883  
[imagixmedical.com](http://imagixmedical.com)