QUANTUM™
MEDICAL IMAGING SERVICES

AGINCOURT PROFESSIONAL CENTRE
2330 KENNEDY ROAD, SUITE 402
SCARBOROUGH, ON M1T-0A2
TEL: 416-756-7667 FAX: 416-756-7841
MON-FRI: 8AM-5PM, SAT: 8AM-4PM
www.qmis.ca

PATIENT INFO

Appt ID:		Patient ID:	
Surname:		First Name	
Birthdate: dd / mm / yyyy	Sex:	Health No:	Version:
Phone: Day:	Cell:	Res:	
Address:		Apt #:	
City:		Postal:	
MINISTRY OF HEALTH REQUIRES A HEALTH CARD TO BE PRESENTED		G R S	

(Office Use Only)

REFERRING PHYSICIAN

☐ **Verbal** ☐ **Fax**
☐ **Copy to:**

Clinical History:

Signature: ----------

GENERAL ULTRASOUND 1

Preparations on other side

Appt Required Time Date dd/mm/yyyy

- ☐ a Abdomen, complete
- ☐ b Abdomen, limited
- ☐ c Female Pelvic transabdominal
- ☐ d Female Pelvic transvaginal
- ☐ e Male Pelvic transabdominal only include pre & post-void volume
- ☐ f Prostate transrectal include kidney, pre & post-void volume
- ☐ g Groin Mass/Inguinal Area
- ☐ h Scrotum
- ☐ i Thyroid & Neck
- ☐ j Parathyroid
- ☐ k Salivary Glands
- ☐ l Neonatal Hips

Areas of Interest:

LMP dd/mm/yyyy

- ☐ m Pregnancy, routine
- ☐ n Pregnancy, 18-20 wks
- ☐ o Pregnancy, high risk
- ☐ p Pregnancy, BPP, AFI, EFW Only
- ☐ q Pregnancy, 11-13 wks, NT for IPS

-also book 18-20 wks morphology scan

BREAST IMAGING 2

Preparations on other side

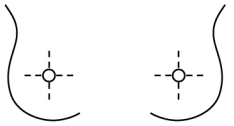
Appt Required Time Date dd/mm/yyyy

- ☐ a Contact patient directly if additional views required
- ☐ b **Screening Mammogram OBSP 50-74 yrs of age** ***0 Implants***
- ☐ c Mammogram ○ R ○ L ***0 Implants***
- ☐ d Coned/Magnification Views ○ R ○ L
- ☐ e Ultrasound* ○ R ○ L

*Not for cancer screening

ontario breast screening program

Right ***Left***



CANADIAN ASSOCIATION OF RADIOLOGISTS MAMMOGRAPHY ACCREDITED

MUSCULO-SKELETAL ULTRASOUND 3

No Preparations Required

Appt Required Time Date dd/mm/yyyy

☐ a Shoulder/AC Joint	○ R ○ L	☐ g Knee	○ R ○ L
☐ b Elbow	○ R ○ L	☐ h Calves	○ R ○ L
☐ c Wrist/Hand	○ R ○ L	☐ i Ankle/Foot	○ R ○ L
☐ d Carpal Tunnel Syndrome	○ R ○ L	☐ j Achilles Tendon	○ R ○ L
☐ e Hip	○ R ○ L	☐ k Plantar Fascia	○ R ○ L
☐ f Hamstring	○ R ○ L		

CARDIOVASCULAR 4

No Preparations Required

ACCREDITED FACILITY IAC INTERSOCIETAL ACCREDITATION COMMISSION VASCULAR TESTING

Appt Required Time Date dd/mm/yyyy

- ☐ a Carotid Duplex
- ☐ b Arterial Duplex / upper extremity
- ☐ c Arterial Duplex / lower extremity
- ☐ d Venous Duplex / upper extremity
- ☐ e Venous Duplex / lower extremity
- ☐ f **Adult Echocardiogram** ♥ Colour Doppler

BONE MINERAL DENSITY 5

Appt Required ~~CBMD~~
No Preparations Required

Time
Date dd/mm/yyyy

- ☐ Hip & Spine -high risk, annual
- ☐ Hip & Spine, first screening
- ☐ Hip & Spine - low risk, routine

- Baseline - once in a lifetime in Ontario
- 2nd Test Low Risk T-Score > -1.0, 3 years after Baseline
- Subsequent Low Risk T-Score > -1.0 , 5 years after 2nd Test
- Subsequent High Risk T-Score < -1.0, once per year
- Bone loss > 1% a year by prev BMD eligible for yearly testing

SPINE & PELVIS

- ☐ Cervical Spine
- ☐ Cervical Spine, Flex & Ext
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Scoliosis Series
- ☐ Sacrum & Coccyx
- ☐ S-I Joints
- ☐ Pelvis Only
- ☐ Pelvis & Hips

SKELETAL SURVEY

- ☐ Arthritic
- ☐ Metastatic
- ☐ Bone Age

OTHER:

☐ _____

GENERAL RADIOGRAPHY 6

Appt Required *No Preparations Required*

Time Date dd/mm/yyyy

ABDOMEN

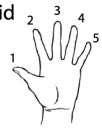
- ☐ KUB
- ☐ Acute ABD

CHEST

- ☐ Chest PA & LAT
- ☐ Chest PA Ins & Exp & Lat
- ☐ Chest PA
- ☐ Sternum
- ☐ Ribs & Chest PA ○ LT ○ RT
- ☐ Immigration

UPPER EXTREMITIES

R	L	
☐	☐	Shoulder
☐	☐	Clavicle
☐	☐	AC Joints
☐	☐	Scapula
☐	☐	Humerus
☐	☐	Elbow
☐	☐	Forearm
☐	☐	Wrist
☐	☐	Scaphoid
☐	☐	Hand
☐	☐	Digit



HEAD & NECK

- ☐ Sinuses
- ☐ Skull
- ☐ Sella Turcica
- ☐ Facial Bones
- ☐ Nose
- ☐ Mandible
- ☐ T.M. Joints
- ☐ Adenoids
- ☐ Mastoids
- ☐ Neck for Soft Tissue
- ☐ Internal Auditory Meati
- ☐ Orbits

LOWER EXTREMITIES

R	L	
☐	☐	Hip
☐	☐	Femur
☐	☐	Knee
☐	☐	Tibia & Fibula
☐	☐	Ankle
☐	☐	Foot
☐	☐	Calcaneus
☐	☐	Toes