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 ☐ **AAA** ☐ **Other:**
- ☐ 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

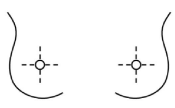
Preparations on other side

Appt Required Time ◷ Date ◌ dd/mm/yyyy

- ☐ a Contact patient directly if additional views required
- ☐ b Screening Mammogram OBSP 50-74 yrs of age ◯ *Implants*
- ☐ c Mammogram ◯ R ◯ L ◯ *Implants*
- ☐ d Coned/Magnification Views ◯ R ◯ L
- ☐ e 3D Tomosynthesis ◯ R ◯ L
- ☐ f ABUS 3D Screening *self-paid ◯ R ◯ L ◯ *Implants*
- ☐ g Ultrasound, targeted* ◯ R ◯ L

*Mark area of concern below; not OHIP/CCO approved for screening

Right *Left*



Toronto Central Regional Cancer Program
Ontario Health (Cancer Care Ontario)

CAR 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
- ☐ b Elbow ◯ R ◯ L
- ☐ c Wrist/Hand ◯ R ◯ L
- ☐ d Carpal Tunnel Syndrome ◯ R ◯ L
- ☐ e Hip ◯ R ◯ L
- ☐ f Hamstring ◯ R ◯ L
- ☐ g Knee ◯ R ◯ L
- ☐ h Calves ◯ R ◯ L
- ☐ i Ankle/Foot ◯ R ◯ L
- ☐ j Achilles Tendon ◯ R ◯ L
- ☐ k Plantar Fascia ◯ 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~~

Preparations on other side

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
- Subsequent Low Risk T-Score > -1.0 , 5 years after 2nd Test
- Subsequent High Risk T-Score < -1.0, once every 3 years

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

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:
- ☐ ----------

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

