

# LAWRENCE - KINGSTON ROAD X-RAY AND ULTRASOUND

4125 Lawrence Ave East, Suite 210  
Scarborough, ON M1E 2S2

**PHONE: (416) 281-4167**

**HOURS:**  
**MON-THURS** 9:00 AM - 6:00 PM  
**FRIDAY** 9:00 AM - 4:00 PM  
**SATURDAY** 9:00 AM - 1:00 PM

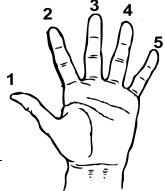

[www.bddiagnostic.com](http://www.bddiagnostic.com)

## PATIENT INFORMATION

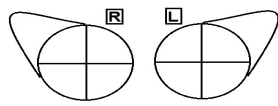
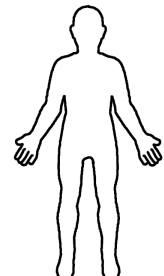

FIRST NAME		
LAST NAME		
DATE OF BIRTH	SEX	TELEPHONE
ADDRESS, CITY, PROV AND POSTAL CODE		
HEALTH NUMBER		VC

DIGITAL X-RAY | ULTRASOUND | BONE MINERAL DENSITY

## X-RAY

<p><b>ABDOMEN</b></p> <p>SINGLE VIEW KUB ABDOMINAL SERIES</p> <p><b>HEAD &amp; NECK</b></p> <p>SKULL SINUSES ADENOIDS S.TISSUE NECK FACIAL BONES MANDIBLE T.M. JOINTS ORBITS/MR NOSE MASTOIDS</p>	<p><b>CHEST</b></p> <p>CHEST R L RIBS STERNUM PA CHEST IMMIGRATION</p> <p><b>SPINE &amp; PELVIS</b></p> <p>CERVICAL SPINE THORACIC SPINE LUMBAR SPINE SCOLIOSIS SERIES L.S SPINE, SI JOINTS &amp; PELVIS SACRUM/COCCYX S.I. JOINTS PELVIS PELVIS AND HIPS</p>	<p><b>UPPER EXTREMITIES</b></p> <p>A.C. JOINTS S.C. JOINTS R L CLAVICLE SHOULDER SCAPULA HUMERUS FOREARM WRIST HAND FINGER # <u>    </u> BONE AGE</p> 	<p><b>LOWER EXTREMITIES</b></p> <p>R L HIP FEMUR KNEE TIBIA &amp; FIBULA ANKLE FOOT CALCANEUS TOE # <u>    </u></p> 
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## ULTRASOUND

GENERAL	MUSCULOSKELETAL	BONE MINERAL DENSITY
<p><b>ABDOMEN</b></p> <p>FEMALE PELVIC TRANSVAGINAL MALE PELVIC/PROSTATE</p> <p><b>OBSTETRICAL:</b></p> <p>ROUTINE HIGH RISK BPP</p> <p><b>SCROTUM</b></p> <p><b>THYROID / NECK</b></p> <p>SALIVARY GLANDS LYMPH NODES</p> <p><b>BREAST</b></p> 	<p><b>UPPER EXTREMITY</b></p> <p>R L SHOULDER/A.C. JOINT ELBOW WRIST HAND</p> <p><b>LOWER EXTREMITY</b></p> <p>R L HIP GROIN HAMSTRING KNEE ANKLE FOOT PLANTAR FASCIA ACHILLES TENDON OTHER AREA <u>                    </u></p> 	<p><b>BASELINE</b></p> <p><b>HIGH RISK ANNUAL</b></p> <p><b>LOW RISK</b> (3 YEARS AFTER BASELINE, SUBSEQUENT STUDIES AFTER 5 YEARS)</p> <p><b>PATIENT NOT PREGNANT</b></p> <p><b>LEAD SHIELDING</b></p>  <p><b>WHEELCHAIR ACCESSIBLE</b></p>

**APPOINTMENT**

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

**CLINICAL INFORMATION**

COPY TO: \_\_\_\_\_

\_\_\_\_\_  
PHYSICIANS SIGNATURE

Ultrasounds are by appointment only. Patients who arrive late for their appointment may be rebooked.  
 (See reverse side for **patient instructions**. Please bring **Health Card** and this **requisition**)