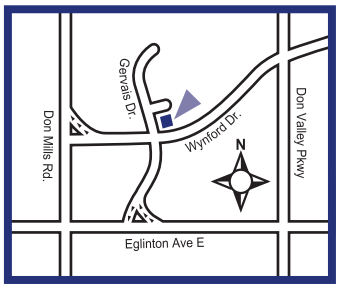
20 WYNFORD
X-RAY & ULTRASOUND

20 WYNFORD DRIVE, SUITE 312
TORONTO, ONTARIO, M3C 1J4
Phone: 416-443-2626
FAX: 416-443-2611

Mon-Fri: 9:00am-5:00pm
Open **Saturdays and Evenings**
(By appointment)
www.wynfordxrayultrasound.ca



NAME _____

PHONE _____

APPT. DATE _____ **TIME** _____

URGENT BOOKING: ☐ **VERBAL:** ☐

REASON FOR EXAM (or Check Box Below)

_____

_____

Dr. _____ **Per** _____

*** PLEASE BRING YOUR HEALTH CARD AND THIS REQUISITION FORM ***

X-RAY (WALK-IN)

ABDOMEN
- ☐ Plain Film (KUB)
- ☐ Acute (3 views)

CHEST
- ☐ Chest (PA/LAT)
- ☐ Ribs R L & Chest PA
- ☐ Sternum
- ☐ S.C. Joints
- ☐ Immigration (PA)

HEAD & NECK
- ☐ Skull
- ☐ Sinuses
- ☐ Adenoids
- ☐ Soft Tissue of Neck
- ☐ Mastoids
- ☐ Nasal Bones
- ☐ Facial Bones
- ☐ Mandible
- ☐ T.M. Joints
- R L Orbits

UPPER EXTREMITIES
- R L Shoulder
- R L Clavicle
- R L A.C. Joints
- R L Scapula
- R L Humerus
- R L Elbow
- R L Forearm
- R L Wrist
- R L Scaphoid
- R L Hand
- R L Digits

No. 1 2 3 4 5

SKELETAL SURVEY
- ☐ Metastatic Series
- ☐ Arthritic Series

LOWER EXTREMITIES
- R L Hip
- R L Femur
- R L Knee
- R L Tib & Fib
- R L Ankle
- R L Foot
- R L Os. Calcis
- R L Toes

No. 1 2 3 4 5

SPINE & PELVIS
- ☐ Cervical Spine
- ☐ Dorsal Spine
- ☐ Lumbo-Sacral Spine
- ☐ Scoliosis Series
- ☐ Sacrum & Coccyx
- ☐ S.I. Joints
- ☐ AP Pelvis

ULTRASOUND (WALK-IN)

GENERAL
- ☐ Abdomen
- ☐ Abdomen / Pelvic
- ☐ Pelvic - Transabdominal
- ☐ Pelvic
  (includes transvaginal,
  unless contraindicated)
- ☐ Transrectal / Prostate
- ☐ Obstetrical < 16 wks
- ☐ Obstetrical > 16 wks
- ☐ Obstetrical (High-Risk)
- ☐ Nuchal Translucency
- ☐ Breast & Axilla R L
- ☐ Testicular
- ☐ Thyroid
- ☐ Neck
- ☐ Inguinal
- ☐ Other Soft Tissue

_____ _____

_____ _____

MUSCULOSKELETAL
- R L Shoulder / Neck Muscles
- R L Elbow
- R L Forearm Muscles
- R L Wrists
- R L Hands
- R L Carpal Tunnel
- R L Hip
- R L Hip Joint
- R L Thigh
- R L Hamstring
- R L Knee
- R L Calf
- R L Ankle
- R L Foot
- R L Achilles Tendons
- R L Plantar Fascia
- R L Other Musculoskeletal

WYNFORD VASCULAR LABORATORY

TEL: (416) 443-2626 **FAX: (416) 443-2611**

APPOINTMENT

DATE: _____

TIME: _____

- ❑ **ARTERIAL DUPLEX:**
  - ❑ **Lower Extremities (Incl. Aorta, ABI)**
  - ❑ **Upper Extremities**
- ❑ **CAROTID DUPLEX**
- ❑ **ECHOCARDIOGRAPHY (2D & Colour Doppler)**
- ❑ **Holter Monitoring** ❑ **48 HRS.** ❑ **72 HRS.**
- ❑ **VENOUS DUPLEX: (❑ DVT, ❑ Venous Insufficiency)**
  - ❑ **Lower Extremities (Incl. iliac veins, IVC)**
  - ❑ **Upper Extremities**
- ❑ **IMAGING for ABDOMINAL AORTIC ANEURYSM**
- ❑ **OTHER** _____

_____

PLEASE SEE PATIENT INSTRUCTIONS ON BACK ⇨