



BEAMSVILLE
DIAGNOSTIC IMAGING

Beamsville Diagnostic Imaging

4438 Ontario Street, Beamsville, ON L0R 1B5

905-563-5000 | Fax: 905-563-5003

email: beamsvillediagnosticsimaging@gmail.com

Other Location:

Barclay Diagnostic Imaging

589 Lake St., #104, St. Catharines, ON

905-934-3838 | Fax: 905-934-5353

www.barclayimaging.com

PATIENT NAME: _____

PATIENT ADDRESS: _____ PATIENT PHONE #: _____

D.O.B: _____ HEALTHCARD #: _____ VC: _____

APPOINTMENT DATE: _____ TIME: _____

REFERRING PHYSICIAN NAME: _____ CC PHYSICIAN: _____

PHYSICIAN SIGNATURE: _____ BILLING # _____

PHYSICIAN PHONE #: _____ PHYSICIAN FAX #: _____

REASON FOR TEST: _____

ULTRASOUND

OBSTETRICAL

- EARLY DATING
- NUCHAL TRANSLUCENCY (11 TO 14 WEEKS)
- ANATOMICAL ASSESSMENT
- GROWTH
- BIOPHYSICAL PROFILE
- LIMITED (I.E. FETAL PRESENTATION)
- HIGH RISK/COMPLICATIONS

SMALL PARTS

- THYROID
- PAROTID
- SUBMANDIBULAR GLAND
- SOFT TISSUE FACE & NECK

ABDOMEN/PELVIS

- ABDOMEN
- ABDOMEN LTD - SPECIFY: _____
- AORTA (AAA)
- KIDNEYS & BLADDER
- APPENDIX
- PELVIC FEMALE MALE
- TRANSVAGINAL
- PELVIC & TRANSRECTAL OF PROSTATE GLAND (TRUS)
- SCROTUM
- HERNIA ASSESSMENT
 - INGUINAL
 - ABDOMINAL WALL

MUSCULOSKELETAL

- SHOULDER (R) (L)
- ELBOW (R) (L)
- WRIST (R) (L)
- HAND (R) (L)
- DIGIT # _____ (R) (L)
- ADULT HIP (R) (L)
- KNEE (R) (L)
- ACHILLES TENDON (R) (L)
- ANKLE (R) (L)
- FOOT (R) (L)
- TOE # _____ (R) (L)
- PLANTAR FASCIA (R) (L)
- LUMP/BUMP (R) (L)
- OTHER: _____

VASCULAR

Done at Barclay Imaging

- CAROTID
- AORTA / ILIAC ARTERIES
- PORTAL VEIN
- A.B.I.
- LOWER EXTREMITY
 - ARTERIAL (R) (L)
 - VENOUS (DVT) (R) (L)
- UPPER EXTREMITY
 - ARTERIAL (R) (L)
 - VENOUS (DVT) (R) (L)
- OTHER: _____

BONE DENSITY (DEXA)

- 1st Baseline BMD In Ontario
- Low Risk (2nd test - 36 months)
- Low Risk (3rd+ test - 60 months)
- High Risk (once every 12 months)

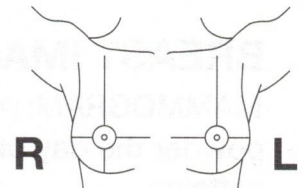
IN ACCORDANCE WITH MINISTRY OF HEALTH ORDERING GUIDELINES

BREAST IMAGING - Done at Barclay Imaging

- BREAST ULTRASOUND (R) (L)
- SCREENING MAMMOGRAM (NON-OBSP)
- DIAGNOSTIC MAMMOGRAM (R) (L)
- IMPLANTS YES NO
- AND/OR CHECK REASON FOR TESTING:
 - LUMP DISCHARGE PAIN SWELLING
- ADDITIONAL IMAGING IF TEST RESULT IS POSITIVE / ABNORMAL



OBSP - SCREENING MAMMOGRAM



Indicate area of concern on diagram

X-RAY (no appointment required)

CHEST

- CHEST P.A. & LAT.
- CHEST P.A. (R) (L)
- RIBS
- STERNUM

ABDOMEN

- ABDOMEN
- ABDOMEN KUB

HEAD & NECK

- SKULL
- SINUSES
- FACIAL BONES
- SOFT TISSUE OF NECK
- ORBITS FOR MRI
- MANDIBLE

SPINE & PELVIS

- CERVICAL SPINE
- THORACIC SPINE
- LUMBAR SPINE
- SACRUM & COCCYX
- S.I. JOINTS
- PELVIS
- THORACOLUMBAR SPINE (SCOLIOSIS SERIES)
- SKELETAL SURVEY

UPPER EXTREMITIES

- ACROMIOCLAVICULAR (A.C.)
- CLAVICLE (R) (L)
- HUMERUS (R) (L)
- SHOULDER (R) (L)
- ELBOW (R) (L)
- FOREARM (R) (L)
- WRIST (R) (L)
- HAND/DIGITS (R) (L)

LOWER EXTREMITIES

- HIP (R) (L)
- FEMUR (R) (L)
- KNEE (R) (L)
- TIBIA & FIBULA (R) (L)
- ANKLE (R) (L)
- FOOT/TOES (R) (L)
- CALCANEUS (R) (L)

STAT : _____