GNMI MEDICAL IMAGING

HAMILTON
260 Nebo Road, Unit# 5
Hamilton, ON L8W 3K5
Phone: (905) 318-4082
Fax: (905) 318-9747

HAMILTON – STONEY CREEK
631 Queenston Road, Unit# 303
Hamilton, ON L8K 6RS Phone:
(905) 560-8434 Fax: (905)
667-3093

GRIMSBY
37 Main Street East #4
Grimsby, ON L3M 1M7
Phone: (289) 797-2330
Fax: (289) 235-8193

FREE PARKING

Patient Information

First Name | Last Name

Home Phone | Cell Phone

Email | M | F | DD / MM / YYYY

OHIP | Version Code | Sex | Date of Birth

Physician Information

Name | Address

Phone | Fax

DD / MM / YYYY | Referring #

Date

Appointment Date/Time

DD / MM / YYYY

Appointment Date | Appointment Time

Please see Patient Instructions on back

24-hour notice required to cancel appointment or $75 charge will be billed to patient.

X-RAY *(No Appointment)*

CHEST
- ❒ Chest PA & LAT
- ❒ Ribs ❒B ❒L ❒R (includes PA chest)
- ❒ Sterno - Clavicular
- ❒ Sternum

HEAD & NECK
- ❒ Soft Tissue
- ❒ Skull
- ❒ Sinuses (uninsured)
- ❒ Facial Bones
- ❒ Nose
- ❒ Mandible
- ❒ Orbits
- ❒ TM Joints

SPINE & PELVIC
- ❒ Hip ❒R ❒L
- ❒ Cervical Spine
- ❒ Thoracic Spine
- ❒ Lumbar (L/S) Spine
- ❒ Pelvis
- ❒ S.I. Joints
- ❒ Sacrum/Coccyx
- ❒ Scoliosis

ABDOMEN
- ❒ ABD Series
- ❒ KUB (single view)

UPPER EXTREMETIES
B = *Bilateral*

B	L	R	
❒	❒	❒	Hand
❒	❒	❒	Wrist
❒	❒	❒	Elbow
❒	❒	❒	Shoulder
❒	❒	❒	Forearm
❒	❒	❒	Humerus
❒	❒	❒	Clavicle
❒	❒	❒	A.C. Joints
❒	❒	❒	Scapula
❒	❒	❒	Scaphoid
❒	❒	❒	Finger: 12345

LOWER EXTREMETIES
B = *Bilateral*

B	L	R	
❒	❒	❒	Knee
❒	❒	❒	Ankle
❒	❒	❒	Foot
❒	❒	❒	Hip
❒	❒	❒	Femur
❒	❒	❒	Tib. & Fib.
❒	❒	❒	Heel
❒	❒	❒	Toe: 12345

❒ Other: _____

ULTRASOUND *(By Appointment)*

GENERAL
- ❒ Abdomen
- ❒ HCC Surveillance/Portal HTN
- ❒ Pelvis - transvaginal
- ❒ Pelvis - transabdominal
- ❒ Renal
- ❒ Bladder
- ❒ PVR - Post Void Residual
- ❒ Transrectal Prostate
- ❒ AAA Screening
- ❒ Abdominal Wall / Hernia
- ❒ Inguinal Canal
- ❒ Scrotum
- ❒ Thyroid
- ❒ Neck

FEMALE PELVIS
- ❒ Pelvis - transvaginal
- ❒ Pelvis - transabdominal

MALE PELVIS
- ❒ Pelvis - transabdominal
- ❒ bladder and prostate
- ❒ Prostate - transrectal

BONE DENSITY (BMD)
- ❒ Baseline
- ❒ 3yr - First follow-up

Low Risk: ❒ 5 year
High Risk: ❒ 1 year

MUSCULOSKELETAL
B = *Bilateral*

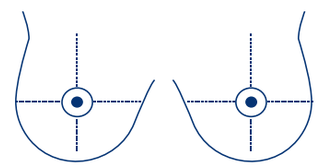
	B	L	R
Shoulder	❒	❒	❒
Elbow	❒	❒	❒
Wrist/Hand	❒	❒	❒
Knee	❒	❒	❒
Achilles Tendon	❒	❒	❒
Ankle	❒	❒	❒
Foot	❒	❒	❒
Plantar Fascia	❒	❒	❒
Lumps & Bumps	❒	❒	❒

VASCULAR LAB
- ❒ Peripheral Arterial Legs - ABI
- ❒ Peripheral Arterial Arms
- ❒ Peripheral Venous Legs - DVT ❒R ❒L ❒ Bil
- ❒ Peripheral Venous Arms - DVT ❒R ❒L ❒ Bil
- ❒ Cartoid Arteries
- ❒ Aorta
- ❒ Portal Venous Hypertension
- ❒ Varicose Vein Assessment

❒ Other: _____

OBSTETRICS LMP: DD / MM / YYYY
- ❒ OB - Under 16 weeks
- ❒ OB - 18-20 weeks
- ❒ OB - Fetal Growth
- ❒ OB - High Risk
- ❒ Biophysical Profile (BPP)
- ❒ Nuchal Translucency-IPS (11-14 weeks)

BREAST ULTRASOUND
❒ R ❒ L ❒ Bilateral



Clinical History Requested

❒ WSIB ❒ STAT

_____ Copy To: _____

Doctor's Signature

MRI & CT

Please see MRI & CT requisition on back.

Urgent-STAT MRI & CT available.

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website:
http://www.health.gov.ca/en/public/programs/ihf/facilities.aspx

www.gnmi.ca **info@gnmi.ca**

Ultrasound Preparation and Instructions

ABDOMEN No eating or drinking (smoking or chewing gum) 4 hours prior to the appointment.

ABDOMEN/PELVIS No eating or drinking 4 hours prior to the appointment. START drinking 5 cups of water (40 oz. or 1.25 litres) 2 hours before your examination. FINISH drinking at least 1 hour prior to your examination. **DO NOT** empty your bladder before your examination. **Note: If your bladder is not full YOUR APPOINTMENT MAY HAVE TO BE RESCHEDULED**

OBSTETRICAL/PELVIS A full bladder is necessary for a thorough examination of the pelvis and pregnant uterus. START drinking 5 cups of water (40 oz. or 1.25 litres) or other fluid 2 hours before your examination. FINISH drinking at least 1 hour prior to your examination. **DO NOT** empty your bladder before your examination. **Note: If your bladder is not full YOUR APPOINTMENT MAY HAVE TO BE RESCHEDULED**

PROSTATE (TRANSRECTAL) **FLEET ENEMA** 2 hours before examination (kit may be purchased at your pharmacy) Drink 34 oz. or 1 Litre of water 1 hour prior to appointment. ***Do not go to the washroom.***

GNMI MEDICAL IMAGING **MRI & CT** MEDICAL IMAGING

❒ **MISSISSAUGA**
10 Kingsbridge Garden Circle
❒ **AJAX**
300 Harwood Avenue South

FREE PARKING
Phone: (905) 568-3768
Fax: (905) 568-0941
www.gnmi.ca **info@gnmi.ca**

Patient First Name _____ Patient Last Name _____ Referring Physician Name _____

Home Phone _____ Cell Phone _____ Phone _____ Fax _____

OHIP# _____ Version Code _____ Sex M | F DD / MM / YYYY (Date of Birth) DD / MM / YYYY (Date)

❒ Non-OHIP/Third-party

❒ WSIB Claim # _____ Injury Date DD / MM / YYYY Company Name _____ Phone _____

CLINICAL HISTORY – EXAM REQUESTED *(Please be specific)*

❒ CT ❒ MRI

Doctor's Signature _____ Copy To: _____

PREVIOUS RELEVANT EXAMS

Please provide all previous reports with requisition
Please state **when** and **where** for each exam

None ❒
MRI ❒ _____
CT ❒ _____
X-ray ❒ _____
Ultrasound ❒ _____
Nuclear Medicine ❒ _____

LIST ALL SURGERY

Please list all surgeries and specify a date and type.
Please provide all surgical reports with requisition.

_____
DD / MM / YYYY

_____
DD / MM / YYYY

Most recent Creatinine/GFR levels within 3 mos:

Creatinine _____ GFR _____

Date DD / MM / YYYY

Date of last menstrual cycle

Date DD / MM / YYYY

Weight _____ Height _____

FOR CT PATIENTS

	YES	NO
Does patient have a history of kidney disease? (e.g., one kidney, renal failure, dialysis)	❒	❒
Is patient diabetic?	❒	❒
Previous reaction to IV contrast?	❒	❒
Is patient taking Metformin or Glucophage?	❒	❒

Please list known allergies:

_____

FOR MRI PATIENTS (To be completed with patient)

	YES	NO
Have you had a previous MRI?	❒	❒
Has metal ever gone into your eye?	❒	❒
Do you have any kidney disease?	❒	❒
Are you on dialysis?	❒	❒
Are you claustrophobic?	❒	❒
Allergy to gadolinium contrast?	❒	❒

Do you have any of the following:

Aneurysm Clips	❒	❒
Artificial Cardiac Valve	❒	❒
Cardiac Pacemaker	❒	❒
Cochlear Implants	❒	❒
Coil/Stents	❒	❒
Neurostimulator	❒	❒
Retained Pacing Wires	❒	❒
Shrapnel/Bullets	❒	❒

Other implanted devices _____

If YES to any, please specify (date, type, implant model):

_____

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***FAX COMPLETED MRI & CT REQUISITIONS TO: (905)-568-0941**
Patient will be directly contacted to schedule an appointment