

<input type="checkbox"/> ALFA-SCAN HAMILTON	<input type="checkbox"/> ALFA-SCAN CALEDONIA
1223 Barton Street East, Unit S4 Hamilton, ON, L8H 2V4 Phone: 905-549-5611 Fax: 905-549-0302 www.alfascan.ca	55 Argyle Street North, Caledonia, ON, N3W 1B8 Phone: 905-765-4059 Fax: 905-765-5755 www.alfascan.ca

Forms can be sent to your preferred location:
 HamiltonBookings@alfascan.ca | CaledoniaBookings@alfascan.ca

PATIENT INFORMATION	REFERRING PRACTITIONER INFORMATION
Last Name: _____	First Name: _____
Phone: _____	Name: _____ Billing Number: _____
OHIP#: _____	Phone: _____ Fax: _____
Appointment Date: _____	Date of Request: _____ Dr. Signature: _____
Clinical Information: _____ _____	Address: _____ Copies to: _____ _____

X-RAY (Walk-In Only)				
HEAD & NECK <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses (Not OHIP Insured) <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Facial Bones <input type="checkbox"/> Mandible <input type="checkbox"/> T.M. Joints <input type="checkbox"/> Orbita (MRI)	ABDOMEN <input type="checkbox"/> Plan Film (KUB) <input type="checkbox"/> Acute SPINE & PELVIS <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Sacrum & Coccyx <input type="checkbox"/> SI Joints <input type="checkbox"/> Scoliosis Series <input type="checkbox"/> AP Pelvis	UPPER EXTREMITIES <input type="checkbox"/> R <input type="checkbox"/> L Shoulder <input type="checkbox"/> R <input type="checkbox"/> L Clavicle <input type="checkbox"/> A.C. Joints <input type="checkbox"/> Scaphoid LOWER EXTREMITIES <input type="checkbox"/> R <input type="checkbox"/> L Hip <input type="checkbox"/> R <input type="checkbox"/> L Femur <input type="checkbox"/> R <input type="checkbox"/> L Knee <input type="checkbox"/> R <input type="checkbox"/> L Tib & Fib	<input type="checkbox"/> R <input type="checkbox"/> L Elbow <input type="checkbox"/> R <input type="checkbox"/> L Forearm <input type="checkbox"/> R <input type="checkbox"/> L Wrist <input type="checkbox"/> R <input type="checkbox"/> L Hand <input type="checkbox"/> R <input type="checkbox"/> L Digits	Additional/Special Views: _____ _____ _____
CHEST <input type="checkbox"/> Chest (PA/LAT) <input type="checkbox"/> R <input type="checkbox"/> L Ribs & Chest PA <input type="checkbox"/> Sternum <input type="checkbox"/> S.C. Joints		No 1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No 1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

BONE MINERAL DENSITY (By Appointment Only)			
<input type="checkbox"/> Baseline	<input type="checkbox"/> High Risk	<input type="checkbox"/> Low Risk	Date of Last BMD: _____

ULTRASOUND EXAMINATION (By Appointment Only)				
<input type="checkbox"/> Abdomen (Full) Instructions: Nothing to eat or drink, 8 hours prior to examination. No coffee, tea, milk, juice or pop. Water OK. <input type="checkbox"/> Abdomen (Limited) Specify: _____	<input type="checkbox"/> Abdomen + Pelvic Instructions: Nothing to eat or drink, 8 hours prior to examination. Drink 4-5 glasses of water (two 500ml water bottles) to be finished one hour before examination. DO NOT VOID. <input type="checkbox"/> Bladder (Pre/Post) <input type="checkbox"/> KUB <input type="checkbox"/> Male Pelvic <input type="checkbox"/> Female Pelvic (includes Transvaginal Unless Contraindicated) <input type="checkbox"/> Transvaginal	OBSTETRICAL - LMP: DD/MM/YYYY <input type="checkbox"/> 1st Trimester <input type="checkbox"/> Anatomy (18-20 weeks) <input type="checkbox"/> Limited OB <input type="checkbox"/> 3rd Trimester Growth/BPP <input type="checkbox"/> Twins <input type="checkbox"/> Other Specify: _____ Instructions: Drink 4-5 glasses of water (two 500ml water bottles) to be finished one hour before examination. DO NOT VOID.	<input type="checkbox"/> R <input type="checkbox"/> L Breast <input type="checkbox"/> R <input type="checkbox"/> L Axilla <input type="checkbox"/> Thyroid <input type="checkbox"/> Neck <input type="checkbox"/> Testicular <input type="checkbox"/> R <input type="checkbox"/> L Inguinal Area <input type="checkbox"/> Chest Masses <input type="checkbox"/> Other Soft Tissue: _____	Instructions: No Preparation

MUSCULOSKELETAL ULTRASOUND (By Appointment Only)				
<input type="checkbox"/> R <input type="checkbox"/> L Shoulder <input type="checkbox"/> R <input type="checkbox"/> L Elbow <input type="checkbox"/> R <input type="checkbox"/> L Forearm	<input type="checkbox"/> R <input type="checkbox"/> L Wrist <input type="checkbox"/> R <input type="checkbox"/> L Hand <input type="checkbox"/> R <input type="checkbox"/> L Calves	<input type="checkbox"/> R <input type="checkbox"/> L Hip <input type="checkbox"/> R <input type="checkbox"/> L Thigh <input type="checkbox"/> R <input type="checkbox"/> L Knee	<input type="checkbox"/> R <input type="checkbox"/> L Ankle <input type="checkbox"/> R <input type="checkbox"/> L Foot <input type="checkbox"/> R <input type="checkbox"/> L Achilles Tendon	<input type="checkbox"/> Other Ultrasound: _____