

PATIENT INFORMATION

Patient Name: _____
 Healthcard/Version Code: _____
 Phone: (day) ____ / ____ (eve.) ____ / ____
 Date of Birth: _____ Age: ____ Sex: M F
 Pregnant: Yes No Lactating: Yes No

Referring MD: _____
 Copies to: _____
 Your appointment: _____ at _____ am pm
 Healthwise to book appointment directly with patient

NUCLEAR CARDIOLOGY

- Exercise perfusion imaging (sestamibi)
- Persantine perfusion imaging (sestamibi)
- Resting radionuclide ventriculogram (MUGA)
- Thallium, rest and redistribution (re: viability)
- If sestamibi study demonstrates ischemia, or other significant finding ('silent' MI or severe LV dysfunction), please arrange consult with Cardiologist**

NUCLEAR MEDICINE

- Bone scan: whole body specific site
- Hepatobiliary scan:
- biliary scan (HIDA)
 - liver RBC SPECT re: ?hemangioma
 - liver sulfur colloid re: ?FNH
- Lung scan (V/Q) Salivary gland scan
- Parathyroid scan Renal scan
- Thyroid scan:
- 24 hour uptake and scan scan only uptake only

BONE MINERAL DENSITOMETRY (ACCREDITED WITH CBMD)

- Screening Follow-up High risk

ULTRASOUND

- Abdominal Pelvic Transvaginal
- Obstetrical - LMP _____
- 1st trimester Anatomy BPP IPS 1
- Testicular Thyroid Other _____
- Musculoskeletal**
- Shoulder R L Both Elbow R L Both
- Knee R L Both Achilles R L Both
- Other R L Both _____

DOPPLER

- Arterial (legs) Arterial (arms)
- Carotid Renal Arteries
- Venous:**
- Both legs Right leg Left leg
- Both arms Right arm Left arm

CARDIAC TESTING

- Ambulatory blood pressure monitoring
 - Echocardiography
 - Exercise stress test (non-nuclear)
 - Resting ECG
- Holter monitoring:** 24 hour 48 hour
- Event monitoring:** 2 week 4 week

XRAY

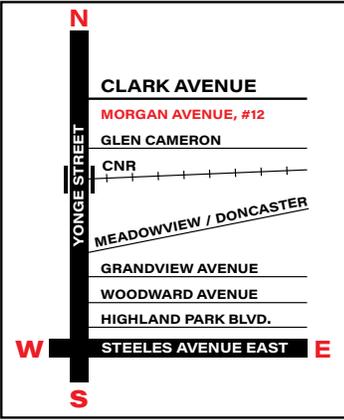
<p>CHEST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest PA & LAT <input type="checkbox"/> Sternum <input type="checkbox"/> SC Joints <input type="checkbox"/> Ribs & Chest PA <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Chest PA Immigration <p>ABDOMEN</p> <ul style="list-style-type: none"> <input type="checkbox"/> KUB <input type="checkbox"/> Acute (3 Views) <input type="checkbox"/> Bone Age 	<p>SPINE & PELVIS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbo-Sacral (LS) <input type="checkbox"/> Sacrum & Coccyx <input type="checkbox"/> S-I Joints <input type="checkbox"/> Pelvis <input type="checkbox"/> Pelvis & Hips <input type="checkbox"/> Pelvis & S-I Joints <input type="checkbox"/> Scoliosis Series <p>SKELETAL SURVEY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritic <input type="checkbox"/> Metastatic 	<p>HEAD & NECK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Nasal Bones <input type="checkbox"/> Mandible <input type="checkbox"/> T.M. Joints <input type="checkbox"/> Mastoids <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Orbits 	<p>UPPER EXTREMITIES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Clavicle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> AC Joints <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Scapula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Humerus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Forearm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Scaphoid <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Digits <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <p>No. 1 2 3 4 5 _____</p>	<p>LOWER EXTREMITIES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Tibia & Fibula <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Calcaneus <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <input type="checkbox"/> Toes <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both <p>No. 1 2 3 4 5 _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Clinical Information/Indication for Test(s):
 Please fax this requisition and any relevant clinical information or diagnostic/lab reports to 905-695-5666 and send any available imaging (eg. X-rays or ultrasounds) with patient.

Physician's Signature _____ Printed Name/Date _____ PLEASE SEE INSTRUCTIONS ON REVERSE

DIRECTIONS TO CLINIC

Healthwise Diagnostics is located at **12 Morgan Avenue Suite 100 on the main floor** 6 blocks north of Steeles Avenue, east off Yonge Street (one block south of Clark Avenue).



PREPARATION FOR TESTS

PLEASE DO NOT FORGET TO BRING YOUR HEALTH CARD AND A LIST OF ALL MEDICATIONS TO EACH APPOINTMENT.

PLEASE BRING RESULTS OF OTHER RECENT TESTS, OR ACTUAL PICTURES (X-RAYS OR ULTRASOUNDS), IF AVAILABLE.

Nuclear Cardiology (Sestamibi)

- ◆ Please bring medications or list of medications.
- ◆ Light breakfast the day of the test, but **no caffeines** (tea, coffee, cola, chocolate) **for 24 hours** prior to your test (and **no decaffeinated** tea/coffee).
- ◆ Be prepared to walk or run on the treadmill - wear a T -shirt, shorts or sweatpants and running shoes.
- ◆ Certain medications should be stopped, if possible, before the test, **if permitted by your doctor**, as follows:

Metoprolol (Lopressor)
 Acebutolol (Monitan; Sectral)
 Diltiazem (Cardizem; Tiazac)
 Carvedilol (Coreg)
 Sildenafil (Viagra)
 Vardenafil (Levitra)
 Aggrenox

LAST DOSE TAKEN 48 HOURS BEFORE THE TEST

Atenolol (Tenormin)
 Nadolol (Corgard)
 Bisoprolol (Monacor)

LAST DOSE TAKEN 72 HOURS BEFORE THE TEST

Tadalafil (Cialis)

LAST DOSE TAKEN 96 HOURS BEFORE THE TEST

THE ABOVE MEDICATIONS MAY BE RESUMED AFTER THE TEST

Biliary Scan

Nothing to eat or drink for 4 hours prior to the scan.

Thyroid Uptake and Scan

- ◆ **If permitted by your doctor:** stop Thyroxine 5 weeks before testing and stop Cytomel 3 weeks before testing.
- ◆ No intravenous contrast material (CT, IVP or angiogram) or seaweed (including sushi) for 5 weeks prior to testing.
- ◆ Stop PTU or Tapazole (methimazole) 5 days prior to testing.

Other Nuclear Medicine Scans & Bone Mineral Densitometry

No special preparation required.

Ultrasound

- ◆ Abdominal: nothing to eat or drink after midnight prior to a morning test. A light breakfast may be eaten prior to an afternoon test.
- ◆ Pelvic/Obstetrical: finish drinking 30 ounces of water 1 hour before the test.
- ◆ Other ultrasound or doppler tests: no preparation required.

Cardiac Testing

No preparation required for echocardiography, Holter monitoring, event monitoring or ambulatory blood pressure monitoring.

Stress Testing (Same preparation as Nuclear Cardiology)

- ◆ Please bring all medications with you.
- ◆ **DIABETICS:**
 - ◆ If **on oral medication:** Eat a light breakfast or lunch and take half your diabetes medication the morning of the test. After the test, you may eat and take the rest of your diabetes medication.
 - ◆ If **on insulin,** on the morning of the test, take half the normal dose and eat a light breakfast.

DURATION OF TESTS: We try to be on time, but please allow adequate waiting time in addition to below.

TESTS	APPROXIMATE DURATION
MYOCARDIAL PERFUSION IMAGING (Sestamibi)	2 hours in AM and 2 hours in PM (5-6 hours total)
BONE SCAN	20 minutes, then 1 hour following a 2-3 hour delay
THYROID SCAN	15 minutes first day, and 1 hour second day
ALL OTHER NUCLEAR SCANS	1-2 hours, on single day (some require up to 4 hour delay after injection)
ULTRASOUND, DOPPLER and ECHO	2 hours in AM and 2 hours in PM (5-6 hours total)
CARDIAC TESTING	1/2 to 1 hour
BONE MINERAL DENSITOMETRY	30 minutes
X-RAY	Variable, depending on wait (no appointment required)