MAYFAIR® DIAGNOSTICS

GENERAL REQUISITION

ALL APPOINTMENTS:
Tel 403.777.3000
Fax 403.777.3001
Toll Free 1.866.611.2665

PATIENT & APPOINTMENT INFORMATION

PLACE PATIENT LABEL HERE

Date of Request (D/M/Y): _____

Name: _____ Female Male

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Other Phone: _____

Date of Birth (D/M/Y): _____

AHC or WCB #: _____

Appt. Date (D/M/Y): _____ **Time:** _____ a.m. p.m.

PROFESSIONAL SERVICES

Please see patient instruction on reverse

X-ray (No appointment necessary, walk-in basis)

- ☐ Examination: _____

General Ultrasound

- ☐ Kidneys and Bladder
- ☐ Abdomen
- ☐ Pelvis: Female (gyne) / Male
- ☐ Thyroid
- ☐ Neck (salivary glands, lymph nodes, mass)
- ☐ Hernia: R L Abdominal wall
- ☐ Scrotum
- ☐ RLQ / Appendix
- ☐ Soft Tissue Mass
- ☐ Other: _____

Musculoskeletal Ultrasound

X-ray of the area may be required if recent trauma, or if no X-ray within last six months

- ☐ Shoulder (Includes Rotator Cuff) ☐ R ☐ L
- ☐ Elbow ☐ R ☐ L
- ☐ Wrist ☐ R ☐ L
- ☐ Carpal Tunnel ☐ R ☐ L
- ☐ Hand or Finger ☐ R ☐ L
- ☐ Hip ☐ R ☐ L
- ☐ Knee (Includes Baker's Cyst) ☐ R ☐ L
- ☐ Ankle ☐ R ☐ L
- ☐ Achilles ☐ R ☐ L
- ☐ Plantar Fascia ☐ R ☐ L
- ☐ Foot or Toe ☐ R ☐ L
- ☐ Muscle/Tendon:
- ☐ Ganglion: _____
- ☐ Other: _____

Obstetrical Ultrasound

- ☐ Complete Obstetrical Assessment (early, NT, detailed)
- ☐ Early Obstetrical (< 14 weeks)
- ☐ Nuchal Translucency (NT) (GA 11w+0d – 13w+6d, preferably after 12 weeks)
- ☐ Detailed exam (> 18 weeks)
- ☐ BPP & growth (> 28 weeks)
- ☐ Other: _____

Vascular Ultrasound

- ☐ Carotid, Vertebral & Subclavian Arteries
- ☐ Carotid Intima-Media Thickness
- ☐ Venous (DVT) ☐ R ☐ L ☐ Arm ☐ Leg

For the following exams fax requisitions to 403.777.3001

- ☐ Arterial Legs + ABI
- ☐ ABI + TBI only
- ☐ Arterial Arms
- ☐ Renal Artery Doppler*

*Requires a previous Renal Ultrasound within the last 12 months.

Bone Mineral Densitometry

- ☐ Bone Mineral Density Evaluation

Nuclear Medicine Imaging

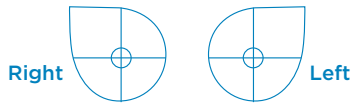
- ☐ Bone Scan
- ☐ Bone Scan with SPECT/CT
- ☐ HIDA Biliary Scan
- ☐ Thyroid Scan

Breast Imaging

- Complete Breast Assessment (Mammography and ABUS/Breast US (if dense breast or as necessary))
- ☐ Screening Mammography (with Tomosynthesis)
- ☐ Diagnostic Mammography (with Tomosynthesis) ☐ R ☐ L ☐ Bilateral
- ☐ Diagnostic Breast Ultrasound ☐ R ☐ L ☐ Bilateral

Intervention

- ☐ Thyroid Biopsy
- ☐ Breast Biopsy (FNA, Core Biopsy, Needle Localization, Stereotactic Biopsy)



Cardiac Imaging (403.568.8677)

Please use Cardiac Assessment requisition.

Image-Guided Procedures

(403.777.3122)
Please use Image-Guided Pain Therapy requisition.

Private Pay Services (403.301.4525)

Please use MRI/CT requisition.

HISTORY & PRESUMPTIVE DIAGNOSIS

Please complete this section with as many details as possible, this enables our clinic staff to provide the most comprehensive patient care.

☐ Stat Phone Report
Phone: _____

☐ Stat Fax Report
Fax: _____

REFERRER INFORMATION

Name: _____

Copy to: _____ ☐ WCB - Alberta

Phone: _____ Fax: _____

Address: _____

Practitioner's ID/Stamp:

☐ Send images with patient (CD copy) Images also available on Netcare.

Signature: _____

Appointments are required for all exams, except X-ray.