Atlas Radiology Consultants

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Ordering Doctor: _____ Date: _____

Ordering Clinic: _____

Address: _____
Street number Suite number

_____
City Province/State Postal Code/Zip

Office Phone Number: (____) _____ Fax Number: (____) _____

Patient Name: _____

Patient DOB: _____ Age/Sex: _____

PHIN: _____ MHSC#: _____

Pertinent clinical details/presumptive diagnosis:

_____

Prior imaging (xray, CT, MRI, US, other): ☐ Prior imaging sent to and reported by to Atlas Radiology
☐ Prior images/reports sent to Atlas Radiology for comparison

US Studies Requested (please check if applicable) ☐ Left ☐ Right ☐ Bilateral

Complete Scan ☐ Shoulder ☐ Elbow ☐ Wrist
☐ Hip ☐ Knee ☐ Ankle

Focused Scans

Shoulder ☐ Acromioclavicular ☐ Sternoclavicular

Elbow ☐ Distal biceps ☐ Lateral ☐ Medial

Hand/Wrist ☐ Trigger finger ☐ Ganglion

Rib ☐ Level _____

Trunk ☐ Abdominal Muscle ☐ Pubic Symphysis

Hip ☐ Anterior ☐ Lateral/gluteal/ITB/trochanter

Thigh ☐ Quadriceps ☐ Hamstring

Knee ☐ Anterior (patella/quad) ☐ Medial ☐ Lateral

Posterior calf ☐

Ankle/foot ☐ Achilles' ☐ Medial ankle ☐ Lateral ankle ☐ Heel/Plantar foot

Toe/finger ☐ Focused (neuroma/bursitis/trauma/ganglion) Digit _____

Nerve ☐ Ulnar nerve ☐ Carpal tunnel ☐ Sciatic N

Other soft tissue ☐ Location _____

☐ Rheumatology screen (list up to 4 body regions)

_____

Additional Comments: -

_____

Scheduling: https://atlasrad.com/msk-ultrasound.html More details: