

The X-Ray Clinic at Northgate Centre^{LP}

Phone/Booking: 780-476-XRAY
(9729)

Suite 2018 & 2062, 9499 – 137 Avenue
(mall upper level above Walmart)
Edmonton, Alberta

Fax: 780-476-9732
www.thexrayclinic.ca



Patient's Name: _____

Appointment Date: DD / MM / YY

Address: _____ City: _____ Postal Code: _____

Phone (Home): _____ Phone (Cell): _____ Phone (Work): _____

Date of Birth: DD / MM / YY Age: _____

Sex: ☐ Male ☐ Female

PHN: _____
(for coverage, please present A.B.H. Card)

WCB ☐

Pregnant:
☐ Yes ☐ No ☐ N/A
Date of L.M.P.:
DD / MM / YY

**WE ACCEPT
SOME WALK-IN
ULTRASOUND
PATIENTS**

☒ X-RAY

WALK-IN : MON – FRI 8:00AM – 6:00PM • SAT 9:00AM – 4:30PM

Examinations(s) requested:

☒ ULTRASOUND

BY APPOINTMENT : MON – FRI 7:00AM – 5:00PM • SAT 9:00AM – 4:30PM

- | | | | | | |
|--|---|---|--|--------------------------------|--|
| <input type="radio"/> Complete Abdomen | <input type="radio"/> Early Pregnancy | <input type="radio"/> Carotid Arteries | <input type="radio"/> Breast <u> </u> L <u> </u> R | MSK: | <input type="radio"/> Achilles |
| <input type="radio"/> Pelvis | <input type="radio"/> Obstetrical Routine | <input type="radio"/> Thyroid | <input type="radio"/> Venous Leg <u> </u> L <u> </u> R | <input type="radio"/> Shoulder | <input type="radio"/> Carpal Tunnel |
| <input type="radio"/> Renal | <input type="radio"/> BPP | <input type="radio"/> Neck | <input type="radio"/> A.B.I. | <input type="radio"/> Knee | <input type="radio"/> Plantar Fascia |
| <input type="radio"/> Urinary Tract | <input type="radio"/> Twins | <input type="radio"/> Peripheral Arterial Screening | <input type="radio"/> Other: _____ | <input type="radio"/> Wrist | <input type="radio"/> Hip Joint |
| <input type="radio"/> Scrotum | <input type="radio"/> Nuchal Translucency | | | <input type="radio"/> Elbow | <input type="radio"/> Trochanteric Bursa |
| | | | | <input type="radio"/> Ankle | |

☒ MAMMOGRAPHY

BY APPOINTMENT : MONDAY – SATURDAY

- ☐ Screening (no signs or symptoms)
☐ Diagnostic (provide history)



☒ BONE MINERAL DENSITOMETRY

BY APPOINTMENT : MONDAY – SATURDAY

- ☐ Thoracic & Lumbar Spine Correlative Radiographs

☒ SIGNIFICANT HISTORY & DIAGNOSIS

☒ STAT REPORT

Practitioner's Name: _____

Signature: _____

Dr.'s Fax #: _____

☐ CC DR: _____

NO APPOINTMENT REQUIRED FOR GENERAL X-RAY