Atlas Radiology Consultants

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INFORMED PATIENT REQUEST FORM

Please have this form completed by your health care provided (physician, chiropractor, therapist, acupuncturist) to confirm you have had an examination and confirmed that a musculoskeletal ultrasound is right for you.

Patient Name: _____

Patient DOB: _____ Age/Sex: _____

PHIN: _____ MHSC#: _____

PROVIDER

Name: _____

Clinic Info:_____

_____
Street number

_____
City Province/State Postal Code

Office Phone: (____) _____

Office Fax: (____) _____

History of present injury:

Pertinent clinical findings:

Other pertinent imaging results:

Provisional diagnosis:

Provider Signature: _____

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

MSK US

(CIRCLE)

Right / Left

COMPLETE

Shoulder
Elbow
Wrist
Hip
Knee
Ankle

FOCUSED

Acromioclavicular
Sternoclavicular
Distal Biceps
Lateral / Medial Elbow
Trigger Finger
Ganglion
Rib
Abdominal Muscle
Pubic Symphysis
Anterior Hip
Lateral Hip/ITB/Trochanter
Quadriceps
Hamstring
Anterior knee/patella/quad
Lateral / Medial Knee
Achilles'
Lateral / Medial Ankle
Heel/plantar hindfoot

NERVE

Ulnar / Carpal Tunnel / Sciatic