

Referring Physician: (print first, last): _____
 CPSO# _____ Signature: _____
 Address: _____
 Office Phone: _____ Office Fax: _____
 Date: dd / mm / yy

Ultrasound Requisition

Please fax to (905) 830-5966

Patient Name: (print first, last) _____		Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>
Address: _____		Patient Weight: _____ kg
Street Number + Name	Apartment	
City	Province	Postal Code
Health Card Number: _____	Version Code: _____	Home: () ()
Other Insurance: _____	Email: _____	
Patient DOES NOT consent to be contacted via: <input type="checkbox"/> Text <input type="checkbox"/> Email (for patient privacy information see the next page)		
Patient not available: From: <u>dd</u> / <u>mm</u> / <u>yy</u> To: <u>dd</u> / <u>mm</u> / <u>yy</u>		
Hoyer Lift Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient arriving by Ambulance Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No

Clinical Question and Relevant Clinical Information:

(must be provided and please be specific)

EXAM REQUIRED (check all that apply)

<p>Abdomen/Pevis</p> <p><input type="checkbox"/> Complete Abdomen <input type="checkbox"/> Kidney(s) <input type="checkbox"/> Kidney(s)/Ureters/Bladder <input type="checkbox"/> Appendix <input type="checkbox"/> Complete Pelvis <input type="checkbox"/> Complete Pelvis and Transvaginal <input type="checkbox"/> Pelvis (pre and post void/prostate) <input type="checkbox"/> Paracentesis Marking</p> <p>Vascular</p> <p><input type="checkbox"/> Renal Artery Doppler <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Portal Hepatic Vein Doppler <input type="checkbox"/> Vein Mapping</p>	<p>General</p> <p><input type="checkbox"/> Thyroid <input type="checkbox"/> Face/Neck <input type="checkbox"/> Thorax/Pleural Space <input type="checkbox"/> Testicles/Scrotum <input type="checkbox"/> Soft Tissue (Specify): <input type="checkbox"/> Baby Head <input type="checkbox"/> Baby Hips</p> <p>Groin:</p> <p><input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat</p> <p>Obstetrical</p> <p><input type="checkbox"/> 1st Trimester <input type="checkbox"/> NT (11-13+6 weeks), bring blood requisition <input type="checkbox"/> Routine Anatomy (18-20 weeks) <input type="checkbox"/> Biophysical Profile (>30 weeks) <input type="checkbox"/> Twins</p>	<p>Musculoskeletal</p> <p>Shoulder <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Elbow <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Hamstrings <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Knee <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Foot <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Achilles Tendon <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Bicep Tendon <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Ankle <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Hand <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat Wrist <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat <input type="checkbox"/> Finger (specify): _____</p> <p>Biopsy</p> <p><input type="checkbox"/> Thyroid FNA (Biopsy) <input type="checkbox"/> Biopsy (specify): _____</p>
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Other Request (not listed above)

Specify:

*Breast (use Medical Arts Building Diagnostic Imaging Requisition)

**PATIENT PREPARATIONS AND INSTRUCTIONS ON REVERSE SIDE.
 PHYSICIANS PLEASE CHECK APPROPRIATE BOX INDICATING PATIENT PREPARATION INSTRUCTIONS**



Diagnostic Imaging

Ultrasound Patient Preparation and Information

PATIENT PREPARATION:

Obstetrical/Pelvic Examinations:

A **full** bladder is required for this examination. **Finish drinking 4 large glasses** (32 oz/950ml) of clear fluid (water, coffee, juice, tea – no milk) **1 hour before** your appointment time. **Do Not Void** until after the examination is finished. This examination usually takes 30 minutes.

Upper Abdomen Examination: (Liver, Pancreas, Gall bladder, Kidneys, Spleen, Aorta, Biliary Tree, Lymph Nodes)

Please **do not eat or drink** for 8 hours before your appointment time. You may take your medication with water. This examination usually takes 30 minutes. For children under 6 years of age: no preparation required.

Combination Examinations:

Upper Abdomen + Pelvis/Obstetrical

A **full** bladder is required for this examination. Please **do not eat** for 8 hours before your appointment. **Finish drinking 4 large glasses** (32 oz/950ml) of clear fluid (water, coffee, juice, tea – no milk) **1 hour before** your appointment time. **Do Not Void** until after the examination is finished. The entire examination usually takes 45 minutes.

Other Ultrasound and Vascular Examinations:

No preparation required.



PRIVACY POLICY DOCUMENTATION

via QR code link below or via Southlake's
privacy office webpage