

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:	Street Number + Name _____	Apartment _____
City _____	Province _____	Postal Code _____
Health Card Number: _____	Version Code: _____	Patient Weight: _____ kg
Other Insurance: _____	Email: _____	Cell: ()
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)

Abdomen/Pevis <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	General <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 Groin: <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Bilat	Musculoskeletal 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):
Vascular <input type="checkbox"/> Renal Artery Doppler <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Portal Hepatic Vein Doppler <input type="checkbox"/> Vein Mapping	Obstetrical <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	Biopsy <input type="checkbox"/> Thyroid FNA (Biopsy) <input type="checkbox"/> Biopsy (specify):

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.

PATIENT INFORMATION:

- **Bring your Ontario Health Card.**
- **Bring this requisition. Diagnostic Imaging cannot perform any procedures without a requisition signed by a Physician or Nurse Practitioner.**
- Upon arrival you are required to register for your appointment at one of our Welcome Centres.
- If you are unable to keep your appointment, please call Patient Scheduling at 905-895-4521, ext. 2665.



PRIVACY POLICY DOCUMENTATION

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