

## Ultrasound Requisition

Please complete all patient and referral fields below

<b>Patient Name:</b> _____	<b>Date:</b> _____	<b>Sex: M / F</b> _____
<b>OHIP / Health Card #:</b> _____	<b>Referred by:</b> _____	
<b>Date of Birth (DD/MM/YY):</b> _____	<b>Appt Date:</b> _____	<b>Time:</b> _____

### EXAMINATIONS REQUESTED

Tick all that apply · R = Right L = Left

ABDOMINAL · GENERAL	HEAD & NECK / SMALL PARTS	MUSCULOSKELETAL
<input type="checkbox"/> Abdomen (Complete) <input type="checkbox"/> Abdomen & Pelvis <input type="checkbox"/> Abdominal Wall <input type="checkbox"/> Kidneys / Bladder (Renal) <input type="checkbox"/> Liver / Gallbladder <input type="checkbox"/> Hernia <input type="checkbox"/> Inguinal / Groin R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Thyroid / Neck <input type="checkbox"/> Parotid / Salivary <input type="checkbox"/> Submandibular <input type="checkbox"/> Lymph Nodes <input type="checkbox"/> Breast R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Axilla R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Soft Tissue / Lump R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Shoulder R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Elbow R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Wrist / Hand R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Hip R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Hamstring R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Knee R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Ankle / Achilles R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Foot / Plantar R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Calf R <input type="checkbox"/> L <input type="checkbox"/> <input type="checkbox"/> Other Musc. R <input type="checkbox"/> L <input type="checkbox"/>
PELVIC / GENITOURINARY	OBSTETRICAL	
<input type="checkbox"/> Female Pelvis (Transabdominal) <input type="checkbox"/> Female Pelvis / Transvaginal <input type="checkbox"/> Male Pelvis <input type="checkbox"/> Prostate (Transrectal) <input type="checkbox"/> Scrotum / Testes <input type="checkbox"/> Bladder (Pre / Post Void)	<input type="checkbox"/> Dating ( < 8 wks ) <input type="checkbox"/> Nuchal Translucency <input type="checkbox"/> Dual Scan / Twins <input type="checkbox"/> 18 to 20 Wks Morphology <input type="checkbox"/> Third Trimester / BPP <input type="checkbox"/> High Risk <input type="checkbox"/> R/O Ectopic	

### CLINICAL INFORMATION / PREVIOUS REPORTS (if any):

\_\_\_\_\_

PHYSICIAN INFORMATION	
<b>Name:</b> _____	<b>Provider Number:</b> _____
<b>Signature:</b> _____	<b>Date:</b> _____
<input type="checkbox"/> Copy report to another physician: Name: _____	

**PLEASE BRING YOUR VALID HEALTH CARD & THIS REQUEST FORM**

PREGNANCY RELEASE
I declare to the best of my knowledge that I am not presently pregnant.
_____ Signature

Please do not bring valuables. The clinic and staff are not responsible for loss or theft of property. No cell phone use inside exam rooms. No food or drink allowed. Findings are not discussed by the clinic. Reports are sent to your physician.