ULTRASOUND REQUISITION

Site:

☐ **London Health Sciences Centre – Vic/Children's** F: 519-667-6826 ☐ **St. Joseph's Health Care London** F: 519-646-6204
☐ **London Health Sciences Centre – UH** F: 519-633-3034

PATIENT INFORMATION:

Surname: _____ **First Name**: _____ **Middle Initial**:_____

Gender: _____ **Date of Birth (YYYY-MM-DD):**_____

Street Address:_____ **Apartment**:_____ **City**: _____ **Province**: _____ **Postal Code**: _____

Telephone (Day):_____ **(Evening)**: _____ **(Cell)**: _____

Health Card No. :_____ **Version Code**:_____ **MRN No.:** _____

Research or 3rd Party No.: _____ ☐ **Outpatient** ☐ **Inpatient** ☐ **ED** ☐ **Long Term Care**

WSIB: ☐ Y ☐ N **WSIB No**.:_____ **Date of Injury (YYYY-MM-DD)**: _____

Mobility: ☐ **Ambulatory** ☐ **Wheelchair** ☐ **Stretcher** ☐ **Mechanical Lift** **Preferred Language**: ☐ **EN** ☐ **Other** _____

Considerations: ☐ **Paediatric** ☐ **Interpreter Required**

ABDOMINAL ULTRASOUND:

☐ **Complete Abdomen & Limited Pelvic**
(Aorta, Gallbladder, Liver, Pancreas, Kidneys, Spleen and Lower Quadrants)
☐ **Limited Abdominal** ☐ **Aorta** ☐ **Liver**
☐ **Renal**
☐ **Other**

GYNECOLOGICAL ULTRASOUND:

☐ **Female Pelvic & Transvaginal**
(Uterus, Ovaries, Bladder and Adnexa)
☐ **Female Pelvic** (Uterus, Ovaries, Bladder and Adnexa)
☐ **Male Pelvic** (Prostate and Bladder)
☐ **Limited Pelvic** (Bladder only)
☐ **Other**

VASCULAR ULTRASOUND:

☐ **Carotid Artery Duplex Doppler**
☐ **Venous Arm Doppler** (DVT) ☐ **Right** ☐ **Left**
☐ **Venous Leg Doppler** (DVT) ☐ **Right** ☐ **Left**
☐ **Arterial Leg Doppler** (Done at Vascular Flow Lab or University Hospital) ☐ **Right** ☐ **Left**
☐ **Arterial Arm Doppler** (Done at Vascular Flow Lab or University Hospital) ☐ **Right** ☐ **Left**

SMALL PARTS ULTRASOUND:

☐ **Hernia** ☐ **Groin** ☐ **Ventral** ☐ **Umbilical** ☐ **Other** _____
☐ **Thyroid**
☐ **Neck**
☐ **Scrotal**

MUSCULOSKELETAL ULTRASOUND:

☐ **Shoulder** ☐ **Right** ☐ **Left**
☐ **Other** _____

OBSTETRICAL ULTRASOUND (All High Risk Obstetrical cases to go to LHSC-VH)

☐ **Enhanced First Trimester Screen** (IPS) **Please fax form**
☐ **Complete Obstetrical** (Recommended booking between 18-20 weeks)
☐ **Recheck Obstetrical**, specify:
☐ **Growth** ☐ **Dating OB**
☐ **Cervical Length** (Transvaginal Ultrasound) ☐ **Placenta Location**
☐ **Other**: _____

HISTORY/CLINICAL FINDINGS: (required) _____

_____

REFERRED BY (please print): _____ **PHYSICIAN SIGNATURE**: _____

Phone Number:_____ **Fax**: _____

BREAST ASSESSMENT FORM MUST BE FILLED OUT FOR ALL BREAST ULTRASOUNDS AND FAXED TO ST. JOSEPH'S *