**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**:

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

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

**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**

**MUSCULOSKELETAL ULTRASOUND:**

**€ Shoulder** **€ Right € Left**

**€** **Other**

**SMALL PARTS ULTRASOUND:**

**€ Hernia** **€ Groin € Ventral € Umbilical € Other**

**€ Thyroid**

**€ Neck**

**€ Scrotal**

**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 \*\****

August 17, 2018, V8