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: 519-663-3034

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 *