hospital SOLDIERS' MEMORIAL ORILLIA

Orillia Soldiers' Memorial Hospital
170 Colborne St. West, Orillia, ON L3V 2Z3 Tel: **705-327-9127** Fax: **705-330-3224**

Request for Ultrasound Examination

(By Appointment Only)

PATIENT INFORMATION	**MRN No.**	**APPOINTMENT DATE:**	**TIME:**
IN-PATIENT **OUT-PATIENT** **ER**			**ARRIVAL TIME:**

Last Name		**First Name**		
Date of Birth (d/m/y)	**M F**	**Health Card No.**	**WSIB No.**	**3rd Party Ins. No.**
Address				
City	**Postal Code**	**Contact Number**	**OK to leave voice mail message**	

PLEASE CHECK (✔) PROCEDURE REQUESTED:

Abdomen/Pelvic

- ABDOMEN
- PORTAL VEIN DOPPLER
- KIDNEYS & BLADDER
- APPENDIX
- PELVIS
- PELVIS/ENDOVAGINAL

Obstetrical

LMP/EDC

Please provide all outside imaging reports.

- 1st TRIMESTER
- eFTS 11-13 weeks (includes NT) TWINS
- ROUTINE ANATOMY (20 weeks) TWINS
- BIOPHYSICAL PROFILE TWINS

Vascular

- CAROTID DOPPLER
- VENOUS LEG(S) RIGHT LEFT BOTH
- VENOUS ARM(S) RIGHT LEFT BOTH

Other

- FACE/NECK/THYROID
- SCROTUM
- SHOULDER(S) RIGHT LEFT BOTH
- MUSCULOSKELETAL (MSK)*
- SOFT TISSUE LUMP *
- NEONATAL HIPS
- NEONATAL HEAD
- NEONATAL SPINE

* Specify location:

RELEVANT CLINICAL HISTORY: *(must be provided and please be specific)*

PHYSICIAN INFORMATION

Physician's Name (Please PRINT clearly)		OFFICE STAMP:
Address/ Phone	**CPSO#**	
Physician's Signature X		

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.