Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

Tel: **705-327-9127** Fax: **705-330-3224**

REQUEST FOR

Ultrasound Examination

• BY APPOINTMENT ONLY •

PATIENT INFORMATION	MRN N⁰.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**
Last Name	First Name		☐ M ☐ F
Date of Birth (D/M/Y)	Health Card N⁰.	WSIB N⁰.	3rd Party Ins. N⁰.
Address	City		Postal Code
Email Address	Contact Number		**OK to leave voice mail message**

Patient is able to give consent for this procedure: ☐ Yes ☐ No

Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ **SDM Name:** ☐ **SDM Contact Information:**

☐ **Patient requires assistance to complete this imaging exam,** *e.g. mobility, translation* **Please Specify:**

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 *
* Specify location:

☐ NEONATAL HIPS
☐ NEONATAL HEAD
☐ NEONATAL SPINE

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

Physician's Name (Please PRINT clearly)	
Phone	**CPSO#**

Physician's Signature

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