Soldiers' MEMORIAL HOSPITAL Orillia

REQUEST FOR

Ultrasound Examination

• BY APPOINTMENT ONLY •

Tel: **705-327-9127** Out-Patient Fax: **705-330-3224** In-Patient Fax: **705-325-0582**

PATIENT INFORMATION

MRN N0.

Isolation Status

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ED ☐ AHF

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
☐ LIMITED ABDOMEN (Specify in Clinical History)
☐ 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
☐ LIMITED OB (Specify in Clinical History)

Small Parts

☐ HERNIA *
☐ SOFT TISSUE LUMP *
☐ MUSCULOSKELETAL (MSK) *
☐ *Specify Location

☐ FACE/NECK/THYROID
☐ SCROTUM
☐ SHOULDER(S) ☐ RIGHT ☐ LEFT ☐ BOTH

Vascular

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

Neonatal

☐ NEONATAL HIPS
☐ NEONATAL HEAD
☐ NEONATAL SPINE

CLINICAL QUESTION AND RELEVANT CLINICAL INFORMATION
(Must be provided and must be specific)

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

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

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