Diagnostic Imaging

ULTRASOUND
CONSULTATION REQUEST

Is the patient hearing impaired? ☐ **Yes** ☐ **No**

Does patient require a lift? ☐ **Yes** ☐ **No**

Appointment Date: _____ **Time**: _____

Guidelines:

1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. **Requisition is to be faxed to the Ultrasound Booking Clerk at 807-684-5854 .**
3. **All Regional referrals are to be faxed to the Regional Booking Office at 807-684-5907.**
4. Completed requisitions will be filed in the Booking Office.

Patient Name: _____ ☐ In-Patient ☐ Out-Patient

Address: _____ Date of Birth _____ /_____ /_____
day month year

_____ Postal Code: _____

Contact Phone Number: _____ Alternate Phone Number:_____ Sex: ☐ Male ☐ Female

Health Insurance Card Number: _____ Version Code: _____

Workplace Safety and Insurance Board (WSIB) Claim Number: _____

ABDOMINAL
- Complete ☐
- Limited ☐
  specify _____
- Aorta ☐
- Gall Bladder ☐
- Pancreas ☐
- Spleen ☐
- Kidney ☐
- Liver ☐
- Urinary Tract ☐
- Thyroid ☐
- Testicular ☐
- Other ☐
  specify _____

PELVIS
- Complete ☐
- Limited ☐
  specify _____
- Intracavity Scan ☐

- Chest ☐
  specify _____

CLINICAL INFORMATION:

_____
_____
_____
_____
_____
_____
_____
_____
_____

MISCELLANEOUS

specify _____
_____
_____

OBSTETRICAL
- Pregnancy less than 16 weeks ☐
- Pregnancy
  - Complete ☐
  - Limited ☐
    specify _____
- Biophysical profile ☐
- Last Menstrual Period _____

VASCULAR STUDIES
- Carotid ☐
- Legs/Arms
  - Arterial Without Exercise ☐
  - Venous Assessment ☐
    specify _____

PRIORITY ASSESSMENT
- ☐ **1 – IMMEDIATE** – Emergent
- ☐ **2 – Within 48 Hours** -Inpatient/Urgent
- ☐ **3 – Within 10 Days** - Semi-urgent
- ☐ **4 – Within 4 Weeks** - Non-urgent

Physician's Name (please print): _____

Physician's Signature: _____ **Date:** _____

FCS-204 Approved April 2007; Rev April 2013, Oct 2015