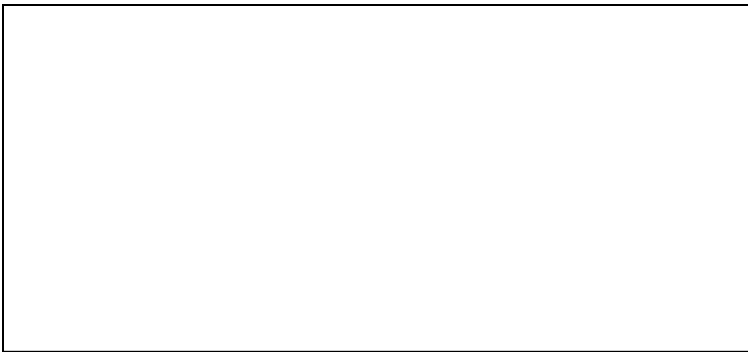




Thunder Bay Regional
Health Sciences
Centre

Diagnostic Imaging

ULTRASOUND
CONSULTATION REQUEST



Regional Inpatient? Yes No
 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. Fax requisitions including Regional referrals to Diagnostic Imaging Central Intake **855-978-1862**.

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 <input type="checkbox"/> Limited <input type="checkbox"/> specify _____ Aorta <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Pancreas <input type="checkbox"/> Spleen <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/>	PELVIS Complete <input type="checkbox"/> Limited <input type="checkbox"/> specify _____ Intracavity Scan <input type="checkbox"/> Chest <input type="checkbox"/> specify _____	CLINICAL INFORMATION: _____ _____ _____ _____ _____ _____
Urinary Tract <input type="checkbox"/> Thyroid <input type="checkbox"/> Testicular <input type="checkbox"/> Other <input type="checkbox"/> specify _____	MISCELLANEOUS specify _____ _____ _____	
OBSTETRICAL Pregnancy less than 16 weeks <input type="checkbox"/> Pregnancy Complete <input type="checkbox"/> Limited <input type="checkbox"/> specify _____ Biophysical profile <input type="checkbox"/> Last Menstrual Period _____	VASCULAR STUDIES Carotid <input type="checkbox"/> Legs/Arms <input type="checkbox"/> Arterial Without Exercise <input type="checkbox"/> Venous Assessment <input type="checkbox"/> specify _____	PRIORITY ASSESSMENT <input type="checkbox"/> 1 – IMMEDIATE – Emergent <input type="checkbox"/> 2 – Within 48 Hours -Inpatient/Urgent <input type="checkbox"/> 3 – Within 10 Days - Semi-urgent <input type="checkbox"/> 4 – Within 4 Weeks - Non-urgent

Physician's Name (please print): _____

Physician's Signature: _____ Date: _____