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 ☐
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:** _____