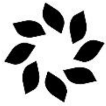


Diagnostic Imaging

# ULTRASOUND
CONSULTATION REQUEST

Patient Name:________________________________
D.O.B. (YYYY-MM-DD):______________________
Address:____________________________________
City/Town, Prov:____________________________
Postal Code: ___________Tel: ______________
Health Card #: ______________Version: ____
Place Patient Label with Barcode HerePlace

**Regional Inpatient?** **Yes** ☐ **No** ☐
**Is the patient hearing impaired?** **Yes** ☐ **No** ☐
**Does patient require a lift?** **Yes** ☐ **No** ☐
**Does patient require an interpreter?** **Yes** ☐ **No** ☐
**Appointment Date**: ______________ **Time**: ________

Guidelines:

1. Healthcare Provider to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. Fax requisitions including Regional referrals to Diagnostic Imaging Central Intake **1-855-978-1862**.

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

**Healthcare Provider's Name (please print):** ________________________________
**Healthcare Provider's Signature:** ________________________________ **Date:** ______________