



# ULTRASOUND REQUISITION

## Site:

- London Health Sciences Centre – Vic/Children’s F: 519-667-6826       St. Joseph’s Health Care London      F: 519-646-6204
- London Health Sciences Centre – UH      F: 519-633-3034

### PATIENT INFORMATION:

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth (YYYY-MM-DD): \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone (Day): \_\_\_\_\_ (Evening): \_\_\_\_\_ (Cell): \_\_\_\_\_

Health Card No. : \_\_\_\_\_ Version Code: \_\_\_\_\_ MRN No.: \_\_\_\_\_

Research or 3<sup>rd</sup> Party No.: \_\_\_\_\_  Outpatient  Inpatient  ED  Long Term Care

WSIB:  Y  N WSIB No.: \_\_\_\_\_ Date of Injury (YYYY-MM-DD): \_\_\_\_\_

Mobility:  Ambulatory  Wheelchair  Stretcher  Mechanical Lift Preferred Language:  EN  Other \_\_\_\_\_

Considerations:  Paediatric  Interpreter Required

### ABDOMINAL ULTRASOUND:

- Complete Abdomen & Limited Pelvic  
(Aorta, Gallbladder, Liver, Pancreas, Kidneys, Spleen and Lower Quadrants)
- Limited Abdominal  Aorta  Liver
- Renal
- Other

### GYNECOLOGICAL ULTRASOUND:

- Female Pelvic & Transvaginal  
(Uterus, Ovaries, Bladder and Adnexa)
- Female Pelvic (Uterus, Ovaries, Bladder and Adnexa)
- Male Pelvic (Prostate and Bladder)
- Limited Pelvic (Bladder only)
- Other

### VASCULAR ULTRASOUND:

- Carotid Artery Duplex Doppler
- Venous Arm Doppler (DVT)  Right  Left
- Venous Leg Doppler (DVT)  Right  Left
- Arterial Leg Doppler (Done at Vascular Flow Lab or University Hospital)  Right  Left
- Arterial Arm Doppler (Done at Vascular Flow Lab or University Hospital)  Right  Left

### SMALL PARTS ULTRASOUND:

- Hernia  Groin  Ventral  Umbilical  Other \_\_\_\_\_
- Thyroid
- Neck
- Scrotal

### MUSCULOSKELETAL ULTRASOUND:

- Shoulder  Right  Left
- Other \_\_\_\_\_

### OBSTETRICAL ULTRASOUND (All High Risk Obstetrical cases to go to LHSC-VH)

- Enhanced First Trimester Screen (IPS) \*\*Please fax form\*\*
- Complete Obstetrical (Recommended booking between 18-20 weeks)
- Recheck Obstetrical, specify:
  - Growth  Dating OB
  - Cervical Length (Transvaginal Ultrasound)  Placenta Location
  - Other: \_\_\_\_\_

**HISTORY/CLINICAL FINDINGS:** (required) \_\_\_\_\_

\_\_\_\_\_

REFERRED BY (please print): \_\_\_\_\_ PHYSICIAN SIGNATURE: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*\*BREAST ASSESSMENT FORM MUST BE FILLED OUT FOR ALL BREAST ULTRASOUNDS AND FAXED TO ST. JOSEPH’S \*\***

