

DIAGNOSTIC IMAGING - ULTRASOUND

U/S



MD Name:	Patient Name:
Signature:	DOB:
MD Phone:	HCN:
Date: (d/m/y)	Home Phone:
Copies to:	Cell Phone
WSIB #:	Address:

**FAX ALL REQUISITIONS TO:
613-969-5561**

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:

PRIORITY: Urgent (specified time: _____) Non-Urgent ED Patient In Hospital ED Patient Call Back

PREFERRED HOSPITAL: BGH TMH PEC NHH

ULTRASOUND

Obstetrical Ultrasound

Prep: finish drinking 1L of water 1 hour prior, full bladder

LMP: EDC (based on LMP):
Based on Dating US:
Gestations: Single Multiple
Ectopic Beta HCG Level:
Dating Scan (< 16 weeks)
Fetal Anatomy Survey(18-22 weeks)
Limited OBS Scan (follow up/
incomplete anatomy @ QHC)

3rd Trimester Assessment (No Prep)

EFW AFI BPP Cord Dop.
Other:

Upper Abdomen (above umbilicus)

NPO 6 hours prior to appointment
AAA Screen
Abdomen
Bariatric Pre-op
Hepatoma Screening
Limited Abdomen (follow-up to
prior @QHC)

Pelvis/Lower Abd (below umbilicus)

Finish Drinking 1L of water 1 hour prior to appointment, full bladder
Appendix
Bladder Post Void Residual
Kidneys & Bladder Only
Pelvis

Vascular Ultrasound: No Prep

Carotid
Venous (DVT)
Leg R L
Arm R L

Peripheral Arterial:

ABI (compression stocking eval.)
Arm (bilateral)
Leg-Initial Screening
Leg- Post Screen @QHC

Superficial Structures: No Prep

Hernia: Abd wall
 Inguinal R L
 Umbilical

Neck (Mass/Salivary Glands)
Testicular/Scrotal
Thyroid
Other

Musculoskeletal: No Prep

Popliteal Fossa: R L
Shoulder R L
(Rotator Cuff)
Achilles Tendon R L
Bicep Brachii Tendon R L
Patellar/Quadracep Tendon R L
Gastronemius R L
Foreign Body(please specify):

Lump (location):

Pediatric Ultrasound 0-5 Years

No Prep Required

Abdomen
Appendix
KUB
Pelvis
Hips-congenital hip dysplasia
(> 6 weeks < 6 mos)BGH Only
Neonatal Brain(< 8 mos)BGH Only
Spine (< 6 mos) BGH Only
Pylorus

Pediatric Ultrasound 6- 12 years

Pediatric Prep Required

Abdomen (NPO 6 Hours prior)

Appendix *(full bladder=*
KUB *500mL of fluid*
Pelvis *1 hour prior to apt.*
 do not empty
 bladder)

OFFICE USE ONLY

Appointment Date & Time: _____

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613 969 5561

