

Waterloo Wellington Hospitals Ultrasound Requisition

OFFICE USE ONLY

Exam Date: _____

Arrival Time: _____

Exam Time: _____

Fax completed requisition to ONE Hospital:

- | | |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> Cambridge Memorial Hospital:(CMH) 519-740-4904 | <input type="checkbox"/> Louise Marshall Hospital: (LMH) 509-509-3884 |
| <input type="checkbox"/> Grand River Hospital: (GRH) 519-749-4296 | <input type="checkbox"/> Palmerston District Hospital:(PDH) 519-343-3821 |
| <input type="checkbox"/> Groves Memorial Community Hospital:(GMCH) 519-843-7637 | <input type="checkbox"/> St. Mary's General Hospital: (SMGH) 519-749-6989 |
| <input type="checkbox"/> Guelph General Hospital: (GGH) 519-766-9982 | |

Patient Information

Last Name, First Name: _____		Health Card #: _____	VC: _____								
DOB: DD/MM/YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female	WSIB? <input type="checkbox"/> Y <input type="checkbox"/> N	Injury Date: DD/MM/YYYY								
Street Address: _____		Please include Claim #: _____									
City/Town: _____		Other Insurance? Third Party or Self Pay									
Province: _____	Postal Code: _____	Specify: _____									
<table border="1"> <thead> <tr> <th colspan="2">Required Patient Information:</th> </tr> </thead> <tbody> <tr> <td>Height: _____(cm)</td> <td>Weight: _____(kg)</td> </tr> <tr> <td><input type="checkbox"/> Restricted Mobility</td> <td><input type="checkbox"/> Outpatient</td> </tr> <tr> <td><input type="checkbox"/> Pediatric Under 10 yrs (Pediatric Under 10 studies not performed at SMGH)</td> <td><input type="checkbox"/> In-Patient Rm/Loc</td> </tr> </tbody> </table>				Required Patient Information:		Height: _____(cm)	Weight: _____(kg)	<input type="checkbox"/> Restricted Mobility	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Pediatric Under 10 yrs (Pediatric Under 10 studies not performed at SMGH)	<input type="checkbox"/> In-Patient Rm/Loc
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Contact Number: _____											
Home: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message											
Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message											
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____											
<input type="checkbox"/> Y <input type="checkbox"/> N An interpreter is required to consent to the procedure. CMH, GGH, GRH and SMGH have interpretation services available.											

EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUISITIONS WILL BE RETURNED**

Ordering Physician Name (Please print): _____	Signature _____	Date _____
Contact #: _____	Fax#: _____	

Copy to (Please print)

Clinical History/Indication (reason for exam): _____ Please contact department with urgent requests

Indicate LMP/EDC:

Select Region/Organ of Interest:

<p>Abdominal Pelvic</p> <input type="checkbox"/> Complete Abdomen <input type="checkbox"/> Portal Hepatic Vein Doppler <input type="checkbox"/> Right Upper Quadrant <input type="checkbox"/> Right Lower Quadrant <input type="checkbox"/> Specify Organ of Interest: _____	<p>Vascular</p> <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Arm Venous Doppler <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Leg Venous Doppler <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other _____	<p>Obstetrical (Not provided at SMGH)</p> <p>1st Trimester</p> <input type="checkbox"/> Dating <input type="checkbox"/> Nuchal Translucency (11 wks 3 days to 13 wks 6 days performed at GGH/GMCH/PDH) <input type="checkbox"/> Other _____	<p>MSK (Performed at all sites)</p> <input type="checkbox"/> Achilles <input type="checkbox"/> R <input type="checkbox"/> L <p>Site Specific MSK (Not Provided at SMGH)</p> <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Kidneys/Ureters/Bladder <input type="checkbox"/> Complete Pelvis (Transvaginal will be performed as required)	<p>Site Specific Vascular GGH, GRH, LMH, PDH Only</p> <input type="checkbox"/> Venous Mapping <input type="checkbox"/> ABIs/Segmental Pressures <input type="checkbox"/> Arterial Extremity Specify Extremity _____ <input type="checkbox"/> Other _____ (arterial extremities and renal doppler studies only available at GGH, LMH and PDH)	<p>2nd Trimester</p> <input type="checkbox"/> Anatomy (18-20 wks) Specify: <input type="checkbox"/> Singleton <input type="checkbox"/> Twin Gender Reported? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Other _____	<p>CMH, GGH, GRH Only</p> <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other _____
<p>Miscellaneous</p> <input type="checkbox"/> Thyroid <input type="checkbox"/> Neck/Salivary Gland <input type="checkbox"/> Testicles/Scrotum <input type="checkbox"/> TRUS (GGH, GRH, SMGH only) <input type="checkbox"/> Soft Tissue Specify: _____ <input type="checkbox"/> Other _____	<p>Neonatal (Not provided at SMGH)</p> <input type="checkbox"/> Pylorus <input type="checkbox"/> Spine	<p>3rd Trimester Check all that apply</p> Specify: <input type="checkbox"/> Singleton <input type="checkbox"/> Twin <input type="checkbox"/> BPP <input type="checkbox"/> Growth <input type="checkbox"/> AFI <input type="checkbox"/> Doppler <input type="checkbox"/> Other _____ Frequency _____	<p>Site Specific Interventional CMH, GGH, GRH, SMGH Only</p> Anticoagulants <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Biopsy _____ <input type="checkbox"/> Drainage _____ <input type="checkbox"/> Injection _____ <input type="checkbox"/> Other _____
<p>Site Specific Neonatal CMH, GGH, GRH Only</p> <input type="checkbox"/> Brain <input type="checkbox"/> Hips		<p>Site Specific Gynecological GGH, GRH Only</p> <input type="checkbox"/> Sonohysterogram	

**for Breast US requests, please refer to Mammography/Breast Imaging requisition

Please indicate location of Imaging examination for Patient:

Cambridge Memorial Hospital 700 Coronation Blvd. Cambridge ON N1R 3G2	Telephone: 519-621-2333 x2230 Fax: 519-740-4904 www.cmh.org	• All patients are to register in the Diagnostic Imaging Department, located on the 1st Floor of the hospital's A Wing , at the indicated arrival time.
Grand River Hospital 835 King St. W Kitchener ON N2G 1G3	Telephone: 519-749-4262 Fax: 519-749-4296 www.grhosp.on.ca	• All patients are to register in the Department of Medical Imaging, located on the 2nd Floor of the hospital's D Wing , at the indicated arrival time.
Groves Memorial Community Hospital 235 Union St. Fergus ON N1M 1W3	Telephone: 519-843-2010 x3234 Fax: 519-843-7637 www.gmch.ca	• All patients are to register in the hospital's Diagnostic Imaging Department, located on the Ground Floor , at the indicated arrival time.
Guelph General Hospital 115 Delhi St. Guelph ON N1E 4J4	Telephone: 519-837-6413 Fax: 519-766-9982 www.gghorg.ca	• All patients are to register in the hospital's Diagnostic Imaging Department, located on the 3rd Floor , at the indicated arrival time.
Louise Marshall Hospital 630 Dublin St. Mt. Forest ON N0G 2L3	Telephone: 519-323-3333 x2253 Fax: www.nwhealthcare.ca	• All patients are to register in the hospital's main registration located on Ground Floor , at the indicated arrival time.
Palmerston and District Hospital 500 Whites Rd. Palmerston ON N0G 2P0	Telephone: 519-343-2030 x4245 Fax: 519-343-3821 www.nwhealthcare.ca	• All patients are to register in the hospital's main registration located on Ground Floor , at the indicated arrival time.
St. Mary's General Hospital 911 Queen's Blvd Kitchener ON N2M 1B2	Telephone: 519-749-6990 Fax: 519-749-6989 www.smgh.ca	• All patients are to register in the hospital's Diagnostic Imaging Department, located on the 1st Floor , at the indicated arrival time.

Exam Preparation

No preparation required for US examinations, except for the following:

- Abdominal Exams: Nothing to eat or drink after midnight until the exam is complete. Necessary medications may be taken
- Abdominal/Pelvic Exams: A full bladder is required for the exam. Nothing to eat or drink after midnight, however, finish drinking one liter of water one hour before your scheduled exam time. DO NOT empty your bladder.
- Pelvis/Pregnancy/Appendix/: Finish drinking one liter of water before your scheduled exam time. DO NOT empty bladder.
- Kidneys/Ureters /Bladder: Finish drinking one liter of water before your scheduled exam time. DO NOT empty bladder.
- Transrectal Prostate: Fleet enema one hour prior to exam.

Important

- Please bring your **Ontario Health Card** and this form to your appointment
- **Patients must be able to consent to the procedure. If language is a barrier, please bring an interpreter.**
- If you are unable to keep your appointment, please give us 24 hours' notice
- We kindly ask that you do not wear or apply fragrances in support of our Fragrance Free policies.