WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

OB ULTRASOUND REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure

Patient Information (Please Print)

Name: _____ Date of Birth (MM/DD/YYYY): _____ Sex: ☐ M ☐ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact # ( ) _____ Secondary # ( ) _____Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ☐ Y ☐ N

CLINICAL HX:

Weeks by dates: _____ LMP: _____ Due Date: _____

- ☐ Assess growth
- ☐ Atypical / Abnormal NST
- ☐ Bleeding
- ☐ Decreased movement
- ☐ Gestational Diabetic
- ☐ High BP
- ☐ IUGR
- ☐ Large for dates
- ☐ No Prenatal Care
- ☐ No Previous History
- ☐ Pain
- ☐ Placenta Previa
- ☐ PROM/PPROM
- ☐ Short Cervix
- ☐ Small for dates

Other: _____

_____

ULTRASOUND INVESTIGATIONS

# of-Weeks Pregnant	Ultrasound Date	Block Booking	Dating	NT	Anatomical Survey	Cervical Length	Biometry Growth	U/A Dopplers	MCA Dopplers	Biophysical Profile	Amniotic Fluid Volume

Print Referring Physician:_____ Fax Number:_____

Referring Physician Signature: _____

Physicians who require copy of report: _____

APPOINTMENT:

DATE (MM/DD/YYYY):_____ TIME: _____ CAMPUS: _____