WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

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 INDICATION

HEAD AND NECK
☐ Head / Brain (Non Vascular)
☐ Face / Neck / Parotid
☐ Thyroid / Nodes / Submandibular

THORAX
☐ Chest

BREAST
☐ R ☐ L ☐ Bilateral

AXILLA
☐ R ☐ L ☐ Bilateral

ABDOMEN, RETROPERITONEUM
☐ Abdomen
☐ Abdomen and Pelvis (combined)
☐ Limited Abdomen - Specify organ:
_____
☐ Kidneys
☐ Renal Bladder
☐ Gall Bladder
☐ Other: _____

PELVIS
☐ Pelvis
☐ Transvaginal - non preg
☐ Sonohysterography
☐ Infertility
☐ Testicular
☐ Post Void Residual
☐ Groin

EXTREMITIES (SOFT TISSUE/MSK)
☐ R ☐ L
☐ Specify area: _____

VASCULAR
☐ Aorta
☐ Carotids
☐ Transcranial Doppler

UPPER EXTREMITY
☐ R ☐ L Venous
☐ R ☐ L Arterial Doppler

LOWER EXTREMITY
☐ R ☐ L Venous
☐ R ☐ L Arterial Doppler

OBSTETRICAL
☐ Preg. for Dating (less than 16 weeks)
☐ Preg. Anatomy (approx. 20-22 weeks)
☐ Preg. Non Routine or High Risk
☐ Preg. Follow up
(Please provide report if original scan not performed at WRH)
☐ Nuchal Translucency (11 - 14 weeks)
☐ Fetal Echo

TRANSRECTAL
☐ Prostate Imaging
☐ Staging (mass)
☐ Fistula

US GUIDED SPECIAL PROCEDURE
☐ Liver Biopsy
☐ Pancreatic Biopsy
☐ Kidney Biopsy
☐ Paracentesis
  ☐ Therapeutic
  ☐ Diagnostic (samples to lab)
☐ Thoracentesis
  ☐ Therapeutic
  ☐ Diagnostic (samples to lab)

Patient on Anticoagulants ☐ Yes ☐ No
Why: Cardiac, DVT, Other: _____
List: _____

OTHER
☐ R ☐ L Breast Biopsy
☐ R ☐ L Axilla Biopsy
☐ R ☐ L Breast Needle Localization
☐ R ☐ L Breast Clip Insertion

☐ Biopsy
Specify Site: _____

☐ Aspiration / Drainage
Specify Site: _____

☐ MSK Injection
Specify Site: _____

☐ Foreign Body Removal
Specify Site: _____

Print Referring Physician: _____ Fax Number:_____

Referring Physician Signature:_____

Physicians who require copy of report:_____

APPOINTMENT:

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