niagarahealth
Extraordinary Caring. Every Person. Every Time.

MUSCULOSKELETAL (MSK) ULTRASOUND REQUISITION

Depending on wait times, patients may be scheduled at any of our hospital sites in the Niagara region

PHONE: 905-378-4647

☐ **St. Catharines Site**
Ext: 46350 Fax: 905-323-7560

☐ **Niagara Falls Site**
Ext: 54947 Fax: 905-358-7438

☐ **Welland Site**
Ext: 33280 Fax: 905-732-9537

☐ **INPATIENT** ☐ **OUTPATIENT**

☐ ED REQUEST ☐ NEXT AVAILABLE

☐ UNIT _____ ☐ WITHIN 1-2 WEEKS

☐ URGENT ☐ ROUTINE

APPOINTMENT DATE/TIME/SITE: _____
DD / MM / YYYY HH : MM SITE

PATIENT INFORMATION (PLEASE PRINT)

PATIENTS LAST NAME	PATIENTS FIRST NAME		
ADDRESS	CITY		
MOBILE PHONE (PREFERRED CONTACT METHOD)	HOME PHONE		
OHCN/OHIP# / VERSION CODE	DATE OF BIRTH (DD/MM/YYYY) / GENDER	☐ WSIB	CLAIM #:

CAN THE PATIENT COME IN ON SHORT NOTICE? ☐ YES ☐ NO

DOES THE PATIENT HAVE ANY ACCESSIBILITY ISSUES? ☐ YES ☐ NO IF YES, SPECIFY:

CAN WE CONTACT YOU BY EMAIL? ☐ YES ☐ NO IF YES, PLEASE PROVIDE YOUR EMAIL ADDRESS:

ORDERING PROVIDER INFORMATION

ORDERING PROVIDER NAME **(PLEASE PRINT)**	COPIES TO
PHONE NUMBER	URGENT RESULTS CONTACT #
SIGNATURE	FAX NUMBER

IT IS THE REFERRING PROVIDERS RESPONSIBILITY TO NOTIFY THE PATIENT OF APPOINTMENT DETAILS

CLINICAL INFORMATION/RELEVANT HISTORY (INCLUDE SPECIFIC QUESTIONS TO BE ANSWERED)

MUSCULOSKELETAL (MSK) ULTRASOUND

☐ **SYNOVITIS (INFLAMMATORY ARTHRITIS)** ☐ R ☐ L SPECIFY JOINT(S): _____

☐ **JOINT EFFUSION** ☐ R ☐ L SPECIFY JOINT(S): _____

☐ **SOFT TISSUE MASS** ☐ R ☐ L ☐ LIPOMA ☐ GANGLION CYST
☐ OTHER (SPECIFY AREA): _____

☐ **MUSCLE INJURY** ☐ R ☐ L SPECIFY MUSCLE / REGION: _____

☐ **NERVE ASSESSMENT** ☐ R ☐ L ☐ ULNAR NERVE ☐ CARPAL TUNNEL
☐ OTHER (SPECIFY AREA): _____

US ASSESSMENTS FOR LIGAMENTS OR CARTILAGE <u>WILL NOT BE ACCEPTED</u> (INCLUDING MENISCI).
ASSESSMENTS FOR GENERALIZED PAIN <u>WILL NOT BE ACCEPTED.</u>

☐ **KNEE** ☐ R ☐ L	☐ PATELLAR TENDON ☐ QUAD TENDON ☐ BAKERS CYST ☐ OTHER TENDON(S) SPECIFY: _____	**NO OTHER INDICATIONS ARE ACCEPTED**
☐ **SHOULDER** ☐ R ☐ L	☐ ASSESS ROTATOR CUFF ☐ LONG HEAD OF BICEPS	**NO OTHER INDICATIONS ARE ACCEPTED**
☐ **ELBOW** ☐ R ☐ L	SPECIFY TENDON / REGION: _____	**WILL NOT ACCEPT GENERALIZED PAIN**
☐ **WRIST** ☐ R ☐ L	SPECIFY TENDON: _____	
☐ **HAND** ☐ R ☐ L	SPECIFY TENDON / REGION: _____	**PULLEY ASSESSMENTS ARE ACCEPTABLE**
☐ **HIP** ☐ R ☐ L	☐ BURSITIS ASSESSMENTS (ILLOPSOAS OR GT) SPECIFY TENDON / MUSCLE: _____	
☐ **ANKLE** ☐ R ☐ L	SPECIFY TENDON: _____	
☐ **FOOT** ☐ R ☐ L	☐ MORTON'S NEUROMA SPECIFY TENDON / REGION: _____	
☐ **OTHER** ☐ R ☐ L	SPECIFY: _____	

FOR MSK XRAY, FILL OUT AN XRAY REQUISITION. FOR MSK CT, FILL OUT A CT REQUISITION. FOR MSK PROCEDURES, FILL OUT AN INTERVENTIONAL RADIOLOGY REQUISITION. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE MSK RADIOLOGIST AS ANOTHER MODALITY MAY BE MORE APPROPRIATE.

HOSPITAL USE ONLY

PLEASE NOTE: INCOMPLETE REQUISITIONS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT

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