niagarahealth
Extraordinary Caring. Every Person. Every Time.

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** ☐ **Fort Erie Site**
Ext: 54947 Fax: 905-358-7438
☐ **Welland Site** ☐ **Port Colborne 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

ORDERING PROVIDER INFORMATION

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

☐ 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:

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

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

ULTRASOUND (WHEN REQUESTING A FOLLOW-UP ON AN ULTRASOUND PERFORMED OUTSIDE OF NH, PREVIOUS REPORTS MUST BE SENT WITH REQUISITION)

ABDOMEN
☐ COMPLETE
☐ LIVER PORTAL DOPPLER
☐ LIVER HCC SCREENING W/ PORTAL DOPPLERS
☐ LIVER ELASTOGRAPHY
☐ RENAL (ONLY)
☐ RENAL & BLADDER
☐ APPENDIX
☐ ABDOMINAL WALL
☐ LIMITED (SPECIFY): _____

PELVIS
☐ BLADDER (ONLY)
☐ FEMALE PELVIS
☐ TRANSVAGINAL
☐ MALE PELVIS (INCLUDING PROSTATE & BLADDER)
☐ TRANSRECTAL
☐ SCROTUM
☐ OTHER: _____

GROIN
☐ R ☐ L OTHER: _____

OBSTETRICAL
LMP: _____ βHCG: _____ EDD: _____
☐ DATING
☐ NUCHAL TRANSLUCENCY
☐ ROUTINE ANATOMY
☐ GROWTH
☐ BPP
☐ TWINS/MULTI
☐ OTHER: _____

WE DO NOT ACCEPT TERTIARY CARE REFERRALS

SMALL PARTS
☐ THYROID
☐ SALIVARY GLAND
☐ LUMP (SPECIFY): _____
☐ LYMPH NODE (SPECIFY): _____
☐ OTHER: _____

PEDS
☐ BRAIN / HEAD
☐ PYLORUS
☐ SPINE
☐ HIPS
☐ OTHER: _____

VASCULAR
VENOUS DOPPLER
LEG ☐ R ☐ L ARM ☐ R ☐ L
ARTERIAL DOPPLER
LEG ☐ R ☐ L ARM ☐ R ☐ L
☐ VENOUS MAPPING (SPECIFY): _____
☐ GRAFT ASSESSMENT (SPECIFY): _____
☐ ABI (ONLY)
☐ ABI (WITH ARTERIAL DOPPLER)
☐ CAROTID DOPPLER
☐ AAA SCREENING
☐ OTHER: _____

ULTRASOUND GUIDED BIOPSY

PLEASE PROVIDE RELEVANT OUTSIDE IMAGING IF ORDERING AN US GUIDED BIOPSY

THYROID ☐ R ☐ L SPECIFY SITE: _____

LYMPH NODE (NOT AXILLARY) ☐ R ☐ L SPECIFY SITE: _____

US EXAMS NOT CURRENTLY PERFORMED AT NH

Doppler renal artery for HTN, Doppler US for penile impotence, Doppler US for temporal arteritis, Doppler US for venous insufficiency, Doppler US for thoracic outlet syndrome, Doppler US for early post-op renal/hepatic transplants, UtA doppler for IUGR, 12 week Fetal anatomy, Tertiary care level fetal anomaly, Comprehensive pelvis US for infiltrative endometriosis, Follicle counting for infertility, Sonohysterography, Bowel wall US for IBD, Endoscopic US, Contrast enhanced US, Evaluation for craniosynostosis
If you have specific questions regarding the appropriate test for your patient, feel free to contact an US Radiologist.

PLEASE USE BREAST IMAGING REQUISITION FOR BREAST/AXILLARY LN BIOPSIES. PLEASE USE THE INTERVENTIONAL RADIOLOGY REQUISITION FOR ALL OTHER BIOPSIES. PLEASE USE THE MUSCULOSKELETAL REQUISITION FOR MSK US.

*****HOSPITAL USE ONLY*****

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