

ULTRASOUND REQUISITION



Department of Diagnostic Imaging
 310 Juliana Drive
 Woodstock, ON N4V0A4
 Phone: 519-421-4204 Fax: 519-421-4241
 Central Bookings
 Phone: 519-537-2381 Fax: 519-421-4238

Patient Information:

Name (Last, First): _____
 DOB: _____ M F PIN: _____
 MMM DD YYYY
 Address: _____
 Phone Number (Home): _____
 (Other): _____
 Health Card Number: _____ Version Code: _____
 WSIB? (Please include approval for specific exam)
 Claim Number: _____ Date of injury: _____
 3rd Party or Insurance (Company or Self-pay): _____
 Does this patient have special needs or impairments?
 (Please specify): _____
 Hold patient Send to Office Other _____

Referring Physician or Other Authorized Health Care Provider

Name (Please Print): _____
 Phone: _____ Fax: _____

Ordering Physician or Authorized Health Care Provider Signature:

Clinical Indication, History: (reason for exam)

Copy to: _____
 Call report to (Phone Number): _____

PATIENTS PRESENTING UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RE-BOOKED
 Please submit completed requisition and all supporting documentation by fax to Central Bookings: 519-421-4238

Examination(s) Requested:

EXAMS REQUIRING PREPARATION	PREPARATION
<input type="checkbox"/> Abdomen <input type="checkbox"/> Kidneys <input type="checkbox"/> Aorta ➔	<ul style="list-style-type: none"> Nothing to eat or drink for 8 hours prior
<input type="checkbox"/> Abdomen and Pelvis <input type="checkbox"/> Kidney and Pelvis (Renal Colic) <input type="checkbox"/> Pelvis and Limited Abdomen (Diverticulitis) <input type="checkbox"/> Pelvis and Limited Abdomen (Appendicitis) ➔	<ul style="list-style-type: none"> Nothing to eat for 8 hours prior No smoking or chewing gum for 8 hours prior Drink 1 litre (32 ounces) of water, and be finished 1 hour before Do not empty bladder
<input type="checkbox"/> Pelvis (Trans-abdominal only) <input type="checkbox"/> Pelvis (Transvaginal, if indicated) <input type="checkbox"/> Obstetrical Routine (greater than 18 weeks or twins) <input type="checkbox"/> Obstetrical Dating <input type="checkbox"/> Obstetrical Integrated Prenatal Screening <input type="checkbox"/> Obstetrical (High Risk) ➔	<ul style="list-style-type: none"> No food restrictions Drink 1 litre (32 ounces) of fluids, and be finished 1 hour before Do not empty bladder
EXAMS WITH NO PREPARATION	EXAMS WITH PREPARATION - SEE PAGE 2 ➔
<input type="checkbox"/> Echocardiography <input type="checkbox"/> Carotid Doppler Right Left <input type="checkbox"/> Thyroid <input type="checkbox"/> Shoulder <input type="checkbox"/> Neck <input type="checkbox"/> Breast (Routine) <input type="checkbox"/> Face <input type="checkbox"/> Knee (for Baker's Cyst) <input type="checkbox"/> Eyes <input type="checkbox"/> Achilles Tendon <input type="checkbox"/> Scrotum (Testicular) <input type="checkbox"/> Arm Arteries <input type="checkbox"/> Groin (Inguinal area) <input type="checkbox"/> Arm Veins <input type="checkbox"/> Chest (Masses) <input type="checkbox"/> Leg Arteries <input type="checkbox"/> Abdominal wall <input type="checkbox"/> Leg Veins (Hernia) <input type="checkbox"/> Soft Tissue Other (specify) _____	<input type="checkbox"/> Hysterosonogram Right Left <input type="checkbox"/> Thyroid Biopsy or Aspiration <input type="checkbox"/> Breast Aspiration <input type="checkbox"/> Lymph Node Biopsy <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Liver Biopsy <input type="checkbox"/> Breast Localization <input type="checkbox"/> Biopsy Other (specify) _____ <input type="checkbox"/> Joint Injection (Knee) <input type="checkbox"/> Paracentesis: <input type="checkbox"/> Therapeutic <input type="checkbox"/> Diagnostic If Diagnostic, specify lab work tests: _____ <input type="checkbox"/> Thoracentesis: <input type="checkbox"/> Therapeutic <input type="checkbox"/> Diagnostic If Diagnostic, specify lab work tests: _____
<p>Note: for Prostate-Transrectal❖ and Prostate-Transrectal Biopsy❖ ❖ Please use separate Prostate-Transrectal requisition and follow instructions from there</p>	
<p>Appointment Date: _____</p>	<p>Appointment Time: _____</p>

PLEASE BRING THIS REQUISITION AND YOUR HEALTH CARD
 Requirements and preparations for examinations provided with requisition on page 2 ➔
 To cancel or reschedule this appointment please call Central Bookings: 519-537-2381



ULTRASOUND EXAMS REQUIRING PREPARATION

EXAM	PREPARATION	DURATION
Abdomen, Kidneys, Aorta	<ul style="list-style-type: none"> Nothing to eat or drink after midnight No smoking or chewing gum for 8 hours prior to and up to appointment time Continue your medications as usual 	30 minutes
Abdomen and Pelvis (Combined), Kidney and Pelvic, Pelvis and Limited- Abdomen	<ul style="list-style-type: none"> Nothing to eat for 8 hours prior No smoking or chewing gum for 8 hours prior to and up to appointment time Continue your medications as usual Finish drinking 1 litre (32 ounces) of water 1 hour PRIOR to your appointment time for the pelvic ultrasound. Your bladder must be full and this exam will be performed first DO NOT EMPTY your bladder unless you experience extreme discomfort and then only empty enough to relieve discomfort (usually about 250-300 mL) <p><u>INSULIN DEPENDENT DIABETIC PATIENT ONLY</u></p> <ul style="list-style-type: none"> Take your normal insulin dose with clear juice (no food) the day of your appointment After exam, resume normal routine 	30 minutes
Pelvic, Obstetrical (Pregnancy), Prostate-Transabdominal (for Prostate-Transrectal, preparation is on page 2 of Prostate-Transrectal requisition)	<ul style="list-style-type: none"> No food restrictions Continue your medications as usual Finish drinking 1 litre (32 ounces) of water 1 hour PRIOR to your appointment time for the pelvic ultrasound. Your bladder must be full for this exam DO NOT EMPTY your bladder unless you experience extreme discomfort and then only empty enough to relieve discomfort (usually about 250-300 mL) <p><u>Note for Obstetrical</u></p> <ul style="list-style-type: none"> The exam must be completed before anyone is brought into the room We ask that you refrain from asking the Sonographer for any ultrasound results during the scan (including sex determination) Your referring physician can provide you with the results at your follow-up appointment and answer any questions at that time 	30 minutes to 1 hour
Hysterosonogram	<ul style="list-style-type: none"> Pregnancy test (blood work) required the day before or 2 hours prior to appointment time (IF NOT POSTMENOPAUSAL). Please arrange through your attending physician Exam should be booked 7-10 days after your period is finished. If you start your period, exam needs to be rescheduled. Please call Central Bookings to reschedule: 519-537-2381 	30 minutes to 1 hour
Breast Localization	<ul style="list-style-type: none"> Please follow instructions as per Pre-Admit Clinic 	
Breast Aspiration, Breast Biopsy, Joint Injection / Aspiration, Thyroid Biopsy / Aspiration, Other Biopsy, Lymph Node Biopsy	<ul style="list-style-type: none"> No restrictions on food or drink No blood thinners (including aspirin), for 10 days prior to procedure If there is a concern regarding this, please advise your attending physician The Ultrasound Department must be notified if there are any modifications to the prep regarding medications 	30 minutes
Liver Biopsy	<ul style="list-style-type: none"> NPO 8 hours prior No blood thinners (including aspirin), for 10 days prior to procedure. If there is a concern regarding this, please advise your attending physician. The Ultrasound Department must be notified if there are any modifications to the prep regarding medications INR and PTT blood work required prior to procedure. If results of INR and PTT are greater than the high range of normal, please have attending physician discuss results with radiologist to confirm whether they will continue with procedure. Notify Ultrasound Department of any changes 	30 minutes to 1 hour
Paracentesis, Thoracentesis	<ul style="list-style-type: none"> No restrictions on food or drinks Continue your medications as usual except blood thinner INR and PTT blood work required prior to procedure. If results of INR and PTT are greater than the high range of normal, please have attending physician discuss results with radiologist to confirm whether they will continue with procedure. Notify Ultrasound Department of any changes 	30 minutes to 1 hour

PLEASE CONTACT YOUR ATTENDING PHYSICIAN FOR ANY QUESTIONS REGARDING YOUR MEDICATIONS
 To cancel or reschedule your appointment please call Central Bookings: 519-537-2381
 For any questions regarding Ultrasound please call: 519-421-4204

Please be aware that this is a "Fragrance Free" facility