

# Waterloo Wellington Hospitals Ultrasound Requisition

Modified on: Thu, 22 Nov, 2018 at 3:18 PM

# Waterloo Wellington Hospitals Ultrasound Requisition

## OFFICE USE ONLY

Exam Date: \_\_\_\_\_

Arrival Time: \_\_\_\_\_

Exam Time: \_\_\_\_\_

### Fax completed requisition to ONE Hospital:

- |  |                     |  |                     |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> Cambridge Memorial Hospital:(CMH)         | <b>519-740-4904</b> | <input type="checkbox"/> Louise Marshall Hospital: (LMH)     | <b>509-509-3884</b> |
| <input type="checkbox"/> Grand River Hospital: (GRH)               | <b>519-749-4296</b> | <input type="checkbox"/> Palmerston District Hospital:(PDH)  | <b>519-343-3821</b> |
| <input type="checkbox"/> Groves Memorial Community Hospital:(GMCH) | <b>519-843-7637</b> | <input type="checkbox"/> St. Mary's General Hospital: (SMGH) | <b>519-749-6989</b> |
| <input type="checkbox"/> Guelph General Hospital: (GGH)            | <b>519-766-9982</b> |  |                     |

### Patient Information

Last Name, First Name: _____		Health Card #: _____ VC: _____	
DOB: DD/MM/YYYY <input type="checkbox"/> Male <input type="checkbox"/> Female		WSIB? <input type="checkbox"/> Y <input type="checkbox"/> N Injury Date: DD/MM/YYYY	
Street Address: _____		Please include Claim #: _____	
City/Town: _____		Other Insurance? Third Party or Self Pay	
Province: _____ Postal Code: _____		Specify: _____	
Contact Number: _____		<b>Required Patient Information:</b>	
Home: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		Height: _____(cm) Weight: _____(kg)	
Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		<input type="checkbox"/> Restricted Mobility <input type="checkbox"/> Outpatient	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		<input type="checkbox"/> Pediatric Under 10 yrs <input type="checkbox"/> In-Patient Rm/Loc	
<input type="checkbox"/> Y <input type="checkbox"/> N An interpreter is required to consent to the procedure. CMH, GGH, GRH and SMGH have interpretation services available.		(Pediatric Under 10 studies not performed at SMGH)	

### EXAM INFORMATION: PHYSICIAN TO COMPLETE \*\*INCOMPLETE REQUISITIONS WILL BE RETURNED\*\*

Ordering Physician Name (Please print): _____		Signature _____ Date _____	
Contact #:	Fax#:		

Copy to (Please print)

**Clinical History/Indication** (reason for exam): \_\_\_\_\_ Please contact department with urgent requests

Indicate LMP/EDC:

### Select Region/Organ of Interest:

<b>Abdominal Pelvic</b> <input type="checkbox"/> Complete Abdomen <input type="checkbox"/> Portal Hepatic Vein Doppler <input type="checkbox"/> Right Upper Quadrant <input type="checkbox"/> Right Lower Quadrant <input type="checkbox"/> Specify Organ of Interest: _____  <input type="checkbox"/> Kidneys/Ureters/Bladder <input type="checkbox"/> Complete Pelvis (Transvaginal will be performed as required)  <b>Miscellaneous</b> <input type="checkbox"/> Thyroid <input type="checkbox"/> Neck/Salivary Gland <input type="checkbox"/> Testicles/Scrotum <input type="checkbox"/> TRUS (GGH, GRH, SMGH only) <input type="checkbox"/> Soft Tissue Specify: _____ <input type="checkbox"/> Other: _____ **for Breast US requests, please refer to Mammography/Breast Imaging requisition	<b>Vascular</b> <input type="checkbox"/> Carotid Doppler <input type="checkbox"/> Arm Venous Doppler <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Leg Venous Doppler <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other _____  <b>Site Specific Vascular</b> <b>GGH, GRH, LMH, PDH Only</b> <input type="checkbox"/> Venous Mapping <input type="checkbox"/> ABIs/Segmental Pressures <input type="checkbox"/> Arterial Extremity Specify Extremity _____ <input type="checkbox"/> Other _____ (arterial extremities and renal doppler studies only available at GGH, LMH and PDH)  <b>Neonatal</b> (Not provided at SMGH) <input type="checkbox"/> Pylorus <input type="checkbox"/> Spine  <b>Site Specific Neonatal</b> <b>CMH, GGH, GRH Only</b> <input type="checkbox"/> Brain <input type="checkbox"/> Hips	<b>Obstetrical</b> (Not provided at SMGH) <b>1st Trimester</b> <input type="checkbox"/> Dating <input type="checkbox"/> Nuchal Translucency (11 wks 3 days to 13 wks 6 days performed at GGH/GMCH/PDH) <input type="checkbox"/> Other _____  <b>2nd Trimester</b> <input type="checkbox"/> Anatomy (18-20 wks) <b>Specify:</b> <input type="checkbox"/> Singleton <input type="checkbox"/> Twin Gender Reported? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Other _____  <b>3rd Trimester Check all that apply</b> <b>Specify:</b> <input type="checkbox"/> Singleton <input type="checkbox"/> Twin <input type="checkbox"/> BPP <input type="checkbox"/> Growth <input type="checkbox"/> AFI <input type="checkbox"/> Doppler <input type="checkbox"/> Other _____ Frequency _____	<b>MSK (Performed at all sites)</b> <input type="checkbox"/> Achilles <input type="checkbox"/> R <input type="checkbox"/> L <b>Site Specific MSK</b> (Not Provided at SMGH) <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L  <b>CMH, GGH, GRH Only</b> <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other _____  <b>Site Specific Interventional</b> <b>CMH, GGH, GRH, SMGH Only</b> <b>Anticoagulants</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Biopsy _____ <input type="checkbox"/> Drainage _____ <input type="checkbox"/> Injection _____ <input type="checkbox"/> Other _____  <b>Site Specific Gynecological</b> <b>GGH, GRH Only</b> <input type="checkbox"/> Sonohysterogram
--	--	---	--

74600126 WWR-US 2018

**Please indicate location of Imaging examination for Patient:**

<b>Cambridge Memorial Hospital</b> 700 Coronation Blvd. Cambridge ON N1R 3G2	Telephone: 519-621-2333 x2230 Fax: 519-740-4904 www.cmh.org	• All patients are to register in the Diagnostic Imaging Department, located on the <b>1<sup>st</sup> Floor</b> of the hospital's <b>A Wing</b> , at the indicated arrival time.
<b>Grand River Hospital</b> 835 King St. W Kitchener ON N2G 1G3	Telephone: 519-749-4262 Fax: 519-749-4296 www.grhosp.on.ca	• All patients are to register in the Department of Medical Imaging, located on the <b>2<sup>nd</sup> Floor</b> of the hospital's <b>D Wing</b> , at the indicated arrival time.
<b>Groves Memorial Community Hospital</b> 235 Union St. Fergus ON N1M 1W3	Telephone: 519-843-5331 x3234 Fax: 519-843-7637 www.gmch.ca	• All patients are to register in the hospital's Diagnostic Imaging Department, located on the <b>Ground Floor</b> , at the indicated arrival time.
<b>Guelph General Hospital</b> 115 Delhi St. Guelph ON N1E 4J4	Telephone: 519-837-6413 Fax: 519-766-9982 www.gghorg.ca	• All patients are to register in the hospital's Diagnostic Imaging Department, located on the <b>3<sup>rd</sup> Floor</b> , at the indicated arrival time.
<b>Louise Marshall Hospital</b> 630 Dublin St. Mt. Forest ON N0G 2L3	Telephone: 519-323-3333 x2253 Fax: www.nwhealthcare.ca	• All patients are to register in the hospital's main registration located on <b>Ground Floor</b> , at the indicated arrival time.
<b>Palmerston and District Hospital</b> 500 Whites Rd. Palmerston ON N0G 2P0	Telephone: 519-343-2030 x4245 Fax: 519-343-3821 www.nwhealthcare.ca	• All patients are to register in the hospital's main registration located on <b>Ground Floor</b> , at the indicated arrival time.
<b>St. Mary's General Hospital</b> 911 Queen's Blvd Kitchener ON N2M 1B2	Telephone: 519-749-6990 Fax: 519-749-6989 www.smgh.ca	• All patients are to register in the hospital's Diagnostic Imaging Department, located on the <b>1<sup>st</sup> Floor</b> , at the indicated arrival time.

**Exam Preparation****No preparation required for US examinations, except for the following:**

- Abdominal Exams: Nothing to eat or drink after midnight until the exam is complete. Necessary medications may be taken
- Abdominal/Pelvic Exams: A full bladder is required for the exam. Nothing to eat or drink after midnight, however, finish drinking one liter of water one hour before your scheduled exam time. DO NOT empty your bladder.
- Pelvis/Pregnancy/Appendix/: Finish drinking one liter of water before your scheduled exam time. DO NOT empty bladder.
- Kidneys/Ureters /Bladder: Finish drinking one liter of water before your scheduled exam time. DO NOT empty bladder.
- Transrectal Prostate: Fleet enema one hour prior to exam.

**Important**

- Please bring your **Ontario Health Card** and this form to your appointment
- **Patients must be able to consent to the procedure. If language is a barrier, please bring an interpreter.**
- If you are unable to keep your appointment, please give us 24 hours' notice
- We kindly ask that you do not wear or apply fragrances in support of our Fragrance Free policies.