Brant Community Healthcare System

Department of Imaging

OBS Ultrasound Requisition

Check box for preferred site

☐ **BGH Site**
200 Terrace Hill St
Brantford, ON N3R 1G9

☐ **TWH Site**
238 Grand River St. N.
Paris, ON N3L 2N7

Tel (519) 751-5599 Fax (519) 751-5582

Name	
Address	
Date of Birth	
Telephone	**(H)** **(W)**
Date of Appt	
Time of Appt	

Healthcard #	
LMP	

Please Check	☐ Prior Reports Faxed ☐ Previous at BGH	☐ Requisition Faxed ☐ No Previous

Examination Requested

☐ **Single** ☐ **Multiple**

☐ Dates/Viability	☐ Follow Up Scan	☐ 3rdTrim+Doppler+BPP
☐ IPS (Integrated Prenatal Screen)	☐ 3rd Trimester Scan	☐ Biophysical Profile(BPP)
☐ 2nd Trimester Screen	☐ 3rd Trimester + Doppler	☐ Doppler

Estimated Date of Delivery: DD/MM/YYYY ☐ **Unknown**

History and Clinical Information Must be Completed

We need this information to provide a proper consultation for your patient. If using a fax to send the request, use the appropriate fax number above. Please send original signed request with the patient.

Patient Prep — **Drink 32 ounces of water. Time your drink to be completed 1 hr prior to appt. DO NOT EMPTY BLADDER.**

Verbal Report Requested ☐ **(Use Discrimination Please)**

Ordering Physician Please Print	Name:		Signature:
	Fax #:		
Extra copies of report to be sent to	Important	Name:	Name:
	Please Print	Fax #:	Fax #:

HEALTH CARD MUST BE PRESENTED AT THE TIME OF EXAMINATION

Revised April 2017 Form # 7125