BRANT COMMUNITY HEALTHCARE SYSTEM

OBS ULTRASOUND REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9

Tel: 519-751-5599 Fax: 519-751-5582

For Office Use Only:
Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION	
Name:		Health Card / Version / DOB (D D M M Y Y Y Y) / Sex (M F U)	
OHIP Billing Number:		First Name:	Last Name:
Address		Address:	
City/Prov.:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:		WSIB Claim #:	Secondary Insurance:
Copies to:		Patient Height:	Patient Weight:

Does Patient Require Assistance? ☐Mechanical Lift ☐ Wheelchair ☐Language Interpreter - Specify:

OBS ULTRASOUND EXAMINATION BY APPOINTMENT ONLY **INCOMPLETE REQUISITIONS WILL BE RETURNED**

☐**SINGLE GESTATION** ☐**TWINS**	**LMP:** _____ DD/MM/YY	**EDC:** _____ DD/MM/YY
☐Dates/Viability ☐Integrated Prenatal Screen (IPS) ☐2nd Trimester Scan	☐3rd Trimester Scan ☐3rd Trimester Scan & Doppler & BPP	☐Dating for TA. Date of Procedure: _____ DD/MM/YY ☐ Other, please specify:

CLINICAL HISTORY: REASON FOR ORDER

Previous Surgeries:

Related Previous Imaging Outside of BGH? ☐**Yes** ☐**No**

Please list and attach reports.

Date	Location	Exam/Report

Once exam is complete, send patient: ☐**Home** ☐**Labour and Delivery**

Please include all relevant patient history including previous reports or consult notes as appropriate.