BRANT COMMUNITY HEALTHCARE SYSTEM

GENERAL 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

Name:	
OHIP Billing Number:	
Address	
City/Prov:	Postal Code:
Phone:	Fax:
Signature:	
Copies to:	

PATIENT INFORMATION

Health Card / Version	DOB (D D M M Y Y Y Y)	Sex (M F U)
First Name:		Last Name:
Address:		
City/Province:		Postal Code:
Phone Number:		Secondary Phone Number:
WSIB Claim #:		Secondary Insurance:
Patient Height:		Patient Weight:

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

ULTRASOUND EXAMINATION (BY APPOINTMENT ONLY) **INCOMPLETE REQUISITIONS WILL BE RETURNED**

General

☐Abdomen
☐Limited Abdomen (focused)
Location _____
☐Pelvis (includes Transvaginal unless contraindicated)
☐Pelvis (excludes Transvaginal)
☐Limited Pelvis (Bladder- Pre and Post void)
☐Male Pelvis
☐KUB (Kidneys, Ureters, Bladder)
☐Abdominal Wall
☐Testicular/Scrotal
☐Hernia Location _____
☐Liver Cirrhosis (Abdomen + Doppler Scan)
☐Lump/Bump Location _____
☐Other _____

Face/Neck

☐Thyroid
☐Lump/Bump Location
_____

Musculoskeletal

☐Achilles Tendon	L☐	R☐
☐Ankle	L☐	R☐
☐Elbow	L☐	R☐
☐Feet	L☐	R☐
☐Hamstring	L☐	R☐
☐Hip	L☐	R☐
☐Knee	L☐	R☐
☐Shoulder	L☐	R☐
☐Wrist	L☐	R☐
☐Other Joint/Muscle	L☐	R☐

Specify: _____

Vascular

☐Carotid
☐Aorta/Iliacs
☐Arterial Extremity
☐Arm L☐ R☐
☐Leg L☐ R☐
☐Venous Extremity
☐Arm L☐ R☐
☐Leg L☐ R☐

Obstetrical

Single ☐Twins☐
LMP _____ DD/MM/YY
EDC _____ DD/MM/YY
☐Dating
☐Nuchal Translucency (IPS)
☐Anatomy Scan (18-21 weeks)
☐3rd Trimester Screen
☐3rd Trimester with BPP

Neonatal

☐Head (open fontanelle)
☐Hips (6weeks to 10 months)
☐Pylorus
☐Spine

Biopsy

☐Thyroid
☐Liver
☐Abdominal
☐Other _____

Patient on Blood Thinners?
Y ☐N☐
If yes specify: _____

For breast ultrasound please use the Breast Imaging Requisition located on our website: www.bchsys.org

CLINICAL HISTORY: REASON FOR ORDER

Previous Surgeries:

Related Previous Imaging: ☐**Yes** ☐**No** **If yes, Where:** **Please attach previous if not completed at BGH.**

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