



200 Fletcher Crescent
Alliston, Ontario L9R 1W7

TO BOOK AN APPOINTMENT:
Phone: 705-434-5133
Fax: 705-434-5111
Please bring a copy of the requisition with you
to your appointment.

APPOINTMENT DATE AND TIME: _____

ROUTINE ULTRASOUND REQUISITION

Name:	Health Card #:
Address:	
Phone #:	DOB: (dd/mm/yy)

- Bring this signed requisition and your health card with you. Failure to do so will result in your appointment being rescheduled.
- Arrive 15 minutes early to register.
- Children, whose caregiver is booked for an appointment for an ultrasound, are **NOT** allowed in during exam.

Clinical information: (required) Check box if urgent

- UPPER ABDOMEN:** Nothing to eat or drink after 10:00 p.m. the evening prior to your exam. No chewing gum or smoking. A small sip of water may be used to take any medication if necessary. For pediatric preparation please call (705) 434-5133.
- PELVIC:** Finish drinking 32 oz. of fluid one hour before your appointment. **DO NOT** empty your bladder until your examination is complete. This examination may be done transvaginally if necessary.
- TRANSVAGINAL:** No preparation.
- OBSTETRICAL:** Finish drinking 32oz. of fluid one hour before your appointment. Please circle the test you are requesting. **DO NOT** empty your bladder until your examination is complete. This examination may be done transvaginally if necessary. Please attach any relevant ultrasound reports.: (1) Dating (2) IPS (3) Anatomy Scan (4) BPP (5) other: explain
- RENAL IMAGING STUDY (RIS) (including kidneys & bladder):** Finish drinking 32oz. of fluid one hour before your appointment. **DO NOT** empty your bladder until your examination is complete.
- AORTA:** No preparation.
- THYROID:** No preparation.
- SCROTAL:** No preparation.
- CAROTID DOPPLER:** No preparation
- VENOUS DOPPLER:** No preparation.
 - RT LEG LT LEG RT ARM LT ARM
- BREAST:** No preparation. Include a diagram and position of lump please.
 - RT BREAST LT BREAST
- OTHER:** _____

Family Physician Name: (print)

Referring Healthcare Provider's Name, Phone and Fax: (print)

Referring Healthcare Provider's Signature:

