WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

OB ULTRASOUND REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure

Patient Information (Please Print)

Name: _____ Date of Birth (D/M/Y): _____ Sex: ❑ M ❑ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact # ( ) _____ Secondary # ( ) _____Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ❑ Y ❑ N

CLINICAL HX:

Weeks by dates: _____ LMP: _____ Due Date: _____

- ❑ Assess growth
- ❑ Atypical / Abnormal NST
- ❑ Bleeding
- ❑ Decreased movement
- ❑ Gestational Diabetic
- ❑ High BP
- ❑ IUGR
- ❑ Large for dates
- ❑ No Prenatal Care
- ❑ No Previous History
- ❑ Pain
- ❑ Placenta Previa
- ❑ PROM/PPROM
- ❑ Short Cervix
- ❑ Small for dates

Other: _____

_____

ULTRASOUND INVESTIGATIONS

# of-Weeks Pregnant	Ultrasound Date	Block Booking	Dating	NT	Anatomical Survey	Cervical Length	Biometry Growth	U/A Dopplers	MCA Dopplers	Biophysical Profile	Amniotic Fluid Volume

Print Referring Physician:_____ Fax Number:_____

Referring Physician Signature: _____

Physicians who require copy of report: _____

APPOINTMENT:

DATE: _____ **TIME:** _____ **CAMPUS:** _____