

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 INDICATION

HEAD AND NECK

- Head / Brain (Non Vascular)
- Face / Neck / Parotid
- Thyroid / Nodes / Submandibular

THORAX

- Chest

BREAST

- R L Bilateral

AXILLA

- R L Bilateral

ABDOMEN, RETROPERITONEUM

- Abdomen
- Abdomen and Pelvis (combined)
- Limited Abdomen - Specify organ: _____
- Kidneys
- Renal Bladder
- Gall Bladder
- Other: _____

PELVIS

- Pelvis
- Transvaginal - non preg
- Sonohysterography
- Infertility
- Testicular
- Post Void Residual
- Groin

EXTREMITIES (SOFT TISSUE/MSK)

- R L
- Specify area: _____

VASCULAR

- Aorta
- Carotids
- Transcranial Doppler

UPPER EXTREMITY

- R L Venous
- R L Arterial Doppler

LOWER EXTREMITY

- R L Venous
- R L Arterial Doppler

OBSTETRICAL

- Preg. for Dating (less than 16 weeks)
- Preg. Anatomy (approx. 20-22 weeks)
- Preg. Non Routine or High Risk
- Preg. Follow up
- (Please provide report if original scan not performed at WRH)
- Nuchal Translucency (11 - 14 weeks)
- Fetal Echo

TRANSRECTAL

- Prostate Imaging
- Staging (mass)
- Fistula

US GUIDED SPECIAL PROCEDURE

- Liver Biopsy
- Pancreatic Biopsy
- Kidney Biopsy
- Paracentesis
 - Therapeutic
 - Diagnostic (samples to lab)
- Thoracentesis
 - Therapeutic
 - Diagnostic (samples to lab)

Patient on Anticoagulants Yes No

Why: Cardiac, DVT, Other: _____
List: _____

OTHER

- R L Breast Biopsy
- R L Axilla Biopsy
- R L Breast Needle Localization
- R L Breast Clip Insertion

Biopsy
Specify Site: _____

Aspiration / Drainage
Specify Site: _____

MSK Injection
Specify Site: _____

Foreign Body Removal
Specify Site: _____

Print Referring Physician: _____ Fax Number: _____

Referring Physician Signature: _____

Physicians who require copy of report: _____

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