STEVENSON MEMORIAL HOSPITAL
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: PRINT CLEARLY OR USE PATIENT LABEL	**Health Card #:**
Address:	
Phone #:	**DOB: (YY/MM/DD)**

- 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 (including IPS):** Finish drinking 32oz. 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. Please attach any relevant ultrasound reports. Please circle the u/s requested.: 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: