NORTHUMBERLAND HILLS HOSPITAL

* N 6 8 1 *

Please fax all requisitions to

NHH DI Bookings at ***(905) 373-6922***

Ultrasound Requisition

Phone (905) 377-7746 Fax (905) 373-6922

Place Patient Identification Label Here

Please indicate √ Examination Requested:

(See reverse for patient preparation instructions)

Routine Ultrasound Requests

- ☐ Abdominal
- ☐ Pelvic/Transvaginal (if indicated)
- ☐ Male Pelvis
- ☐ Scrotal/Testicular
- ☐ Kidney/Ureters/Bladder (KUB)
- ☐ Thyroid
- ☐ Neck
- ☐ Carotid Doppler
- ☐ Other_____

Venous Doppler

- ☐ Right Leg ☐ Right Arm
- ☐ Left Leg ☐ Left Arm

Inguinal Hernia

- ☐ Right ☐ Left

Obstetrical Ultrasound

- ☐ Dating <14w
- ☐ Routine Anatomy (19w to 21w)
- ☐ OBS Biophysical Profile / High Risk
- ☐ Nuchal Translucency (NT)
  11w to 13w 6d gestation

Last Name: _____

First Name: _____

Address: _____

City: _____ P. Code _____

Phone: (____) _____-_____ D.O.B: _____

Health Card #:

☐☐☐☐ ☐☐☐ ☐☐☐ ☐☐ (HC version code)

WSIB Claim #: _____

☐ DI will contact patient directly with an appointment unless this box is checked

☐ Speak to Patient only ☐ Patient's consent to leave message

☐ Contact POA or other _____

Contact's Name: _____ Tele#: _____

Ordering Physician/Practitioner Data

Name:

OHIP Billing #:

CPSO #:

Copies To:
(Include Address)

_____

For NHH Emergency Department Use ONLY

- ☐ **Urgent: within 24 hours**
- ☐ **Urgent: within 48 hours**
- ☐ **Semi-Urgent: < 1 week**
- ☐ **Elective: > 1 week**

If Priority is not indicated,
U/S requests will be booked as Elective

History:

Physician's/Practitioner's Signature

PREVIOUS RELEVANT TESTS (WHERE/WHEN):
Please provide copies of the results/reports.

U/S:_____ **X-RAY:** _____ **CT:** _____
MRI: _____ **NUC MED:**_____ **Other:** _____

Appointment Date: _____ **Time:** _____

You must bring this requisition with you!

Northumberland Hills Hospital is fragrance free. Perfume, after shaves or colognes, strongly scented soaps or deodorant are not permitted due to potential allergic reactions by both patients and staff.

PLEASE FOLLOW PREPARATION INSTRUCTIONS on the back of this form **Form: 681 (10/19)**

Ultrasound Preparation Instructions

Abdominal Ultrasound:

- *morning appointment:* Do not eat or drink anything† after 10 pm on the evening before your test.
- *afternoon appointment*:: Do not eat or drink anything† after 8 am on the day of your test.

Pelvic Ultrasound:

- Drink three (3) glasses of water (8 ounces /250 mL each) before your test. You should be finished drinking this by one hour before your appointment time. Do not void (empty your bladder) after drinking this water as your bladder must be full for a successful test. In certain special circumstances, an ultrasound probe may be inserted internally.

Kidneys Ureters Bladder and/or Prostate and/or Post Void Residual

- Please follow the instructions for **Pelvis Ultrasound**.

Obstetrical Ultrasound:

- *before 20 weeks (4 1/2 months)*: Follow the instructions listed for pelvic ultrasound above.
- *after 20 weeks (4 1/2 months)*: No preparation is required.

Nuchal Translucency Ultrasound:

- *Nuchal Translucency ultrasound examinations should be performed between 11w and 13w 6d gestation.*
- *eFTS blood work is also required to be taken on the same day as the NT ultrasound is performed.*

Other ultrasound tests: No preparation is required.

†If you require heart medications, you should take these as per your normal routine, using very small sips of water.

‡Clear fluids include apple juice, clear jellies, consommé, water, and tea. They do not include milk, coffee, or orange juice.