Perth and Smiths Falls District Hospital

ULTRASOUND REQUEST

Office Use Only

Appt: _____

☐ Patient notified: _____

☐ **Smiths Falls Campus**
60 Cornelia St W, Smiths Falls, ON K7A 0A4
FAX: (613)283-3036
Reception: (613) 283-2330 Ext: 1409

☐ **Perth GWM Campus**
33 Drummond Street West, Perth, ON K7H 2K1
Fax: (613) 267-1172
Reception: (613) 283-2330 ext. 1409

Please arrive 15 minutes before your appointment to allow time for registration. If you arrive late, your appointment may need to be rescheduled.

Outpatient ultrasound appointments: Your healthcare provider **must fax your ultrasound request**. You will be contacted with your appointment date and time. Incomplete forms may be returned for clarification.

Important: Please follow the exam preparation instructions provided to you. If you arrive unprepared, your appointment may need to be rescheduled.

Patient Name: _____ Primary Phone Number: _____
Date of Birth: _____ Alternate Phone Number: _____

ABDOMEN/PELVIS:

☐ ABDOMEN COMPLETE
(Liver, GB, Pancreas, Spleen, Kidney, Aorta)

☐ ABDOMEN LIMITED
- ☐ Appendix
- ☐ Hernia
- ☐ FILI: _____

☐ KIDNEYS/BLADDER

☐ BLADDER (Pre & Post Void)

☐ PELVIS

_____

OBSTETRICAL:

☐ 1st TRIMESTER

☐ 2nd TRIMESTER (Morphology)

☐ BPP (Biophysical Profile)

☐ EFW (Estimated Fetal Weight)

☐ Follow Up Morphology

LNMP: _____

OTHER:

☐ THYROID

☐ NECK/FACE

☐ SCROTAL/TESTES

☐ BREAST(S)
- ☐ RIGHT
- ☐ LEFT

☐ AXILLA(E)
- ☐ RIGHT
- ☐ LEFT

☐ SHOULDER
- ☐ RIGHT
- ☐ LEFT

☐ EXTREMITY
Specify: _____

☐ OTHER
Specify: _____

VASCULAR:

☐ CAROTID DOPPLER

☐ CARDIAC ULTRASOUND/ ECHOCARDIOGRAM **(GWM Site only)**

☐ ANKLE BRACHIAL INDEX (ABI) PERIPHERAL ARTERIAL DOPPLER

☐ DVT (Venous Doppler)
- Right Leg
- Left Leg
- Right Arm
- Left arm

'Please call department to book same day"

☐ VENOUS COMPETENCE
(SF Site only)

Clinical History

☐ Urgent (within 1week)
☐ High Priority (within 2 weeks)
☐ Routine (next available appt)

_____
Healthcare Provider Name (please print) / Signature

Perth and Smiths Falls District Hospital

PATIENT INFORMATION FOR ULTRASOUND STUDIES

Appointment Details

Please note your scheduled **date, time, and location**:

☐ **Smiths Falls Campus** ☐ **Perth GWM Campus**

Booking & Changes

- **Do not call to book your appointment.**
  Your healthcare provider has sent us the requisition, and we will contact you to schedule your exam.
- **Call us if you need to cancel or reschedule**, with at least **24 hours' notice**.
  Smiths Falls: (613) 283-2330 ext. 1409
  Perth GWM: (613) 283-2330 ext. 1409

Day of Your Exam

Do not smoke on the day of your exam.
Do not wear scented products.
For pregnancy exams, **one adult only** may be in the scan room.
Young children are not allowed in the exam room.

Preparation Instructions *(Follow the instructions for your specific exam)*

Abdominal Ultrasound

- No food, gum, or smoking for **6 hours** before your exam.
- Water is allowed.
- Take your medications.
- Diabetics may have juice if needed.

Pelvic / Abdominal & Pelvic Ultrasound

- **Full bladder required.**
- Drink **5 cups (40 oz / 1.5 L)** of clear, non-carbonated fluids
  (start 2 hours before, finish 1 hour before your appointment).
- **Do not empty your bladder.**
- Eat and take medications as usual.
- Catheters must be clamped before drinking.

Pregnancy Ultrasound (All Trimesters)

- **Full bladder required** (same drinking instructions above).
- **Do not empty your bladder.**
- Eat and take medications as usual.
- One adult allowed in the scan room.

Biophysical Profile (BPP)

- Drink sweetened juice or soda **within 30 minutes** of your exam.
- Eat and take medications as usual.

All Other Ultrasounds

- No preparation required.
- Eat, drink, and take medications as usual.

Please arrive **15 minutes early** for registration.