

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

Healthcare Provider Name (please print) / Signature