



**ULTRASOUND REQUISITION**  
**201 GEORGIAN DRIVE**  
**BARRIE, ON L4M 6M2**  
**TEL. (705) 739-5610 FAX. (705) 739-5649**

Patient Name: (print first, last)	
Address:	
Health Card Number:	Version Code:
Other Insurance:	
Home: ( )	Work/Other: ( )

<b>RELEVANT CLINICAL INFORMATION:</b> (must be provided and please be specific)	<b>Appointment Date:</b> MM / DD / YYYY
	<b>Appointment Time:</b>
	<b>Arrival Time:</b>
	<b>Hospital Record #:</b>
	<b>Date of Birth:</b> MM / DD / YYYY
	<b>Patient weight:</b> kg

**PLEASE CHECK (✓) PROCEDURE REQUESTED. See Patient Preparation on Reverse**

<b>ABDOMEN/PELVIC</b>	<b>OBSTETRICAL</b>
<input type="checkbox"/> Upper Abdomen	<input type="checkbox"/> 1st Trimester
<input type="checkbox"/> Renal Imaging Study (Kidney/Bladder)	<input type="checkbox"/> NT (11 to 13+6 weeks). Bring blood requisition and EFTS forms
<input type="checkbox"/> Appendix	<input type="checkbox"/> Routine anatomy (19-21 weeks)
<input type="checkbox"/> Female Pelvis/Endovaginal	<input type="checkbox"/> Placental Insufficiency
<input type="checkbox"/> Male Pelvis (Pre & Post Void/Prostate)	<input type="checkbox"/> Third Trimester Growth
	<input type="checkbox"/> Twins
	<input type="checkbox"/> Biophysical Profile <input type="checkbox"/> MCA Doppler
<b>VASCULAR</b>	<b>OTHER</b>
<input type="checkbox"/> Carotid Doppler	<input type="checkbox"/> Face/Neck/Thyroid <input type="checkbox"/> Pediatric Spine
<input type="checkbox"/> Venous leg(s) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Thyroid biopsy <input type="checkbox"/> Pediatric Hips
<input type="checkbox"/> Venous Arm(s) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Scrotum <input type="checkbox"/> Neonatal Head
<input type="checkbox"/> Arterial Leg(s) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Thorax/Pleural Space <input type="checkbox"/> Hysterosonogram
<input type="checkbox"/> ABI / TBI	<input type="checkbox"/> Shoulder(s) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Arterial Arm(s) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Soft Tissue (specify above)
	<input type="checkbox"/> Musculoskeletal (specify above)

**BREAST:** (Please use RVH Mammography and Breast Ultrasound Requisition RVH-0403)

**PATIENT PREPARATIONS AND INSTRUCTIONS ON REVERSE SIDE.**  
**PHYSICIANS PLEASE CHECK APPROPRIATE BOX INDICATING PATIENT PREPARATION INSTRUCTIONS**

<b>Referring Physician</b> (print first, last) <b>Signature:</b>	<b>Date:</b> MM / DD / YYYY
<b>Signature:</b>	<b>Office Phone:</b> ( )
<b>Address:</b>	<b>Fax Number:</b> ( )





Royal Victoria  
Regional Health Centre

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## Patient Preparation and Information

- Abdomen** Please do not eat or drink for 8 hours before your appointment time. No smoking or chewing gum for 2 hours before examination. You may take your medication with water.
- Pelvic** Drink 4 cups of water 1 hour before your appointment time. DO NOT VOID until after the examination is finished.
- Abdomen and Pelvic** Please do not eat for 8-hours before your appointment time. No smoking or chewing gum for 2-hours before examination. Drink 4 cups (8 ounces) of water 1-hour prior to your appointment. Do not void until after the exam is finished.
- Endovaginal** No preparation is necessary.
- Renal Imaging Study (RIS)** Patient may eat a normal diet but a full urinary bladder is required. Drink 4 cups of water 1 hour before your appointment time. DO NOT VOID until after the examination is finished.
- Obstetrical**
  - 10 weeks or less – no preparation is required.
  - 11 weeks or greater – a full bladder is required. Drink 4 cups of water 1-hour before your appointment time. Do not void until after the exam.

### No preparation is required for the following exams:

- Thyroid**
- Venous Leg Doppler**
- Venous Arm Doppler**
- Arterial Arm Doppler**
- Arterial Leg Doppler**
- Carotid Doppler**
- Breast**
- Shoulder**
- Hysterosonogram**
- Musculoskeletal**

