MEDICAL IMAGING REQUISITION

To book a test, please Fax/Digital Transfer requisition to

Central Scheduling Owen Sound: 1-855-702-1968

Rural Scheduling: 1-855-978-1809

Please complete in full, as incomplete requisitions will be returned.

Prefered Site:
- ☐ Owen Sound
- ☐ Southampton
- ☐ Markdale
- ☐ Meaford
- ☐ Wiarton
- ☐ Lion's Head (X-ray only)

For appointment notification purposes, please provide the following patient information:
Email: **Mobile phone number:**

PATIENT IDENTIFICATION:

Legal Name on HC: *(last, first)*	DOB: *(yyyy-mmm-dd)*
Preferred Name:	Telephone: Mobile:
Sex: Gender: Pronouns:	City: Province:
Health Card No: Version Code:	Postal Code:

PREFERRED PRIORITY: ❒ Within 2 weeks ❒ Routine ❒Required Follow up Due:

Clinical Information: Mandatory ❒ Stretcher ❒ Wheel Chair

Disposition Post-Imaging: ❒ Patient to return to sending facility ❒Send to: ❒ To see:

ULTRASOUND EXAMINATIONS:

GENERAL ULTRASOUND
- ☐ Abdomen (gallbladder, pancreas, spleen, liver, kidneys, aorta)
- ☐ Abdomen/Pelvis complete
- ☐ KUB (kidneys, ureters, urinary bladder)
- ☐ Groin/Hernia: R☐ L☐
- ☐ Abdomen Limited: _____
- ☐ Abdominal Doppler Specify: _____

For Breast Appointments, please fill out Mammography Breast Imaging Requisition

FEMALE PELVIS (Full Bladder required)
- ❒ Pelvis
- ❒ Transvaginal

MALE PELVIS
- ❒ Pelvis (bladder, prostate)

SMALL PARTS
- ☐ Face/Neck: _____
- ☐ Thyroid
- ☐ Scrotum
- ☐ Soft tissue/lump: _____

OBSTETRICAL **LMP:**_____ **EDC:**_____
- ☐ OB Dating (Less than 16 weeks)
- ☐ Nuchal Translucency (11-13 weeks, 6 days) eFTS
- ☐ Routine Anatomy Scan (18-20 weeks)
- ☐ Bio Physical Profile (Great than 30 weeks)
- ☐ OB High Risk/Fetal Growth
- ☐ Twins
- ☐ OB Follow up: _____

VASCULAR
- ☐ Arterial Extremity R/O PVD Arm: R☐ L☐ Leg: R☐ L☐
- ☐ Venous Extremity R/O DVT Arm: R☐ L☐ Leg: R☐ L☐
- ☐ Carotid Doppler (Bilat)

PEDIATRICS
- ☐ Brain
- ☐ Abdo/Pelvis: _____
- ☐ Pyloric Stenosis
- ☐ Hip Dysplasia (4 weeks- 6 months)
- ☐ Spine (0- 9 months)

MUSCULOSKELETAL (LIMITED STUDIES)
- ☐ Quad
- ☐ Patellar
- ☐ Bicep
- ☐ Achilles
- ☐ Laterality Effected: _____
- ☐ Bakers Cyst: R☐ L☐
- ☐ Other (Soft Tissue): _____

NUCLEAR MEDICINE (OS Site Only):

Exam Required:

X-RAY:

Exam Required**:**

REFERRING PROVIDER:

Referring Provider:	CPSO Number:
Telephone: Fax:	CC Report to:
Signature:	Decision Date: