STEVENSON
MEMORIAL HOSPITAL

200 Fletcher Crescent
Alliston, Ontario L9R 1W7

TO BOOK AN APPOINTMENT:
Phone: 705-434-5133
Fax: 705-434-5111
Please bring a copy of the requisition with you to your appointment.

APPOINTMENT DATE AND TIME:_____

ROUTINE ULTRASOUND REQUISITION

Name:	**Health Card #:**
Address:	
Phone #:	**DOB:** (dd/mm/yy)

- Bring this signed requisition and your health card with you. Failure to do so will result in your appointment being rescheduled.
- Arrive 15 minutes early to register.
- Children, whose caregiver is booked for an appointment for an ultrasound, are **NOT** allowed in during exam.

Clinical information: (required) ☐ Check box if urgent

☐ **UPPER ABDOMEN**: Nothing to eat or drink after 10:00 p.m. the evening prior to your exam. No chewing gum or smoking. A small sip of water may be used to take any medication if necessary. For pediatric preparation please call (705) 434-5133.

☐ **PELVIC:** Finish drinking 32 oz. of fluid one hour before your appointment. **DO NOT** empty your bladder until your examination is complete. This examination may be done transvaginally if necessary.

☐ **TRANSVAGINAL**: No preparation.

☐ **OBSTETRICAL**: Finish drinking 32oz. of fluid one hour before your appointment. Please circle the test you are requesting. **DO NOT** empty your bladder until your examination is complete. This examination may be done transvaginally if necessary. Please attach any relevant ultrasound reports.: (1) Dating (2) IPS (3) Anatomy Scan (4) BPP (5) other: explain

☐ **RENAL IMAGING STUDY (RIS) (including kidneys & bladder):** Finish drinking 32oz. of fluid one hour before your appointment. **DO NOT** empty your bladder until your examination is complete.

☐ **AORTA:** No preparation.

☐ **THYROID**: No preparation.

☐ **SCROTAL**: No preparation.

☐ **CAROTID DOPPLER**: No preparation

☐ **VENOUS DOPPLER**: No preparation.
☐ RT LEG ☐ LT LEG ☐ RT ARM ☐ LT ARM

☐ **BREAST**: No preparation. Include a diagram and position of lump please.
☐ RT BREAST ☐ LT BREAST

☐ **OTHER**:_____

Family Physician Name: *(print)*

Referring Healthcare Provider's Name, Phone and Fax: *(print)*

Referring Healthcare Provider's Signature: