Central Health

# ULTRASOUND

Date Received by MI Dept.

**REQUEST FOR EXAM & CONSULTATION**

**Medical Imaging**

***INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED***

**1** **EXAM REQUIRED:** _____

**2** **PATIENT INFORMATION:**

**Status:** ☐ OUTPATIENT ☐ INPATIENT
☐ MCP ☐ WHSCC ☐ NR ☐ DVA ☐ DND
☐ OTHER

Name: _____

Address: _____

_____

City: _____ Postal Code: _____

DOB: _____ Sex: _____

Phone: _____ (Work): _____

MCP #: _____ Chart #: _____

**3** **Please identify urgency:**

| **Priority** Circle appropriate number | **Specific Date?** D/M/Y |
|---|---|
| **1 Urgent** (0-14 days) | |
| **2 Non-Urgent** (0-30 days) | |
| **3 Follow-up (Date MUST be Specified)** | |

**4** **To be completed by Medical Imaging:**

**Appointment date:** _____

**Patient Notified:** ☐ Phone ☐ Message ☐ Mail

**Patient preparation instructions:** ☐ Yes ☐ No

**Exam protocol :**

**5** **CLINICAL INFORMATION:**

Is patient on Warfarin, ASA or other anticoagulant? ☐ Yes ☐ No

Is patient receiving Metformin or Glucophage? ☐ Yes ☐ No

Has patient received IV contrast before? ☐ Yes ☐ No

Has patient had an adverse reaction to IV contrast? ☐ Yes ☐ No

Does patient have any contact precautions? ☐ Yes ☐ No

Does patient have any allergies? ☐ Yes ☐ No

Describe any allergies and reactions: _____

_____

Is patient breastfeeding? ☐ Yes ☐ No

**Patient's LMP**: _____

List any medications the patient is taking:

_____

_____

_____

**6** **CLINICAL INDICATIONS FOR EXAM** (including previous relevant studies): _____

_____

_____

_____

_____

**CLINICAL DIAGNOSIS:** _____

_____

**7** **Requesting Physician (PRINT & SIGN):** _____

**Date:** _____ **Phone Number:** _____

**Report to be sent to Dr. (PLEASE PRINT):** _____

*Adapted from Eastern Health, January 2008.*

*FRM - DIS022*