DIAGNOSTIC IMAGING – ULTRASOUND

Huntsville District Memorial Hospital
100 Frank Miller Drive
Huntsville, ON, P1H 1H7
T: 705-789-2311 x2242
F: 705-788-1485

South Muskoka Memorial Hospital
75 Ann Street
Bracebridge, ON, P1L 2E4
T: 705-645-4404 x3112
F: 705-645-7567
PATIENT BOOKING LINE: 1-877-348-6264

Patient Demographics:

Name Last First

Address

Home Phone ( ) - Other Phone ( ) -

☐ **Do not contact patient.** Provide appointment date/time to referring provider.

DOB YYYY / MM / DD ☐ Male ☐ Female

OHIP

Urgency ☐ < 24 hours ☐ 2-3 days ☐ <14 days ☐ Date Specific_____ ☐ Routine

Precautions : **Mobility** _____ **Isolation** _____ **Other**_____

Patient Location ☐ Inpatient ☐ Emerg patient ☐ Outpatient ☐ LTC

Relevant Clinical History:

Examination preparation may be required

WSIB claim #:_____

Abdomen

- ☐ Biliary / RUQ
- ☐ Complete
- ☐ Renal
- ☐ Portal Doppler
- ☐ AAA
- ☐ RLQ/ appendix
- ☐ Other : specify _____

Obstetrical

LMP: _____
EDD_____

- ☐ Routine/anatomy 20wks = wk of: _____
- ☐ Biophysical Profile
- ☐ Follow up
- ☐ Dating
- ☐ eFTS / NT (requires separate eFTS and lab req)

US Interventional

- ☐ FNA Site: _____
- ☐ Core Biopsy Site: _____
- ☐ Breast biopsy Site _____
- ☐ Clip
- ☐ Localization/MOLLI
- ☐ Aspiration Specify: _____
- ☐ Drain insertion Site_____
- ☐ Transrectal Prostate biopsy (urologist only)
- ☐ Injection Site: _____

Pelvic

- ☐ Urinary Tract/KUB
- ☐ Male Pelvis
- ☐ Female Pelvis (includes transvaginal unless contraindicated or refused)

Small Part/Vascular

- ☐ Neck and or Face
- ☐ Thyroid
- ☐ Testicles/Scrotum
- ☐ Carotid
- ☐ MSK specify: _____

R	L	
☐	☐	Leg Veins (DVT only)
☐	☐	Arm Veins (DVT only)
☐	☐	Breast
☐	☐	Shoulders
☐	☐	Groin
☐	☐	Hip for bursitis or CHD

Referring Provider:	Signature:	
Copies to:	Date:	OHIP Billing #:

These examinations must be booked; please fax requisition. Preparation will be given at time of booking.