Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING–**GENERAL ULTRASOUND**

Tel: 613-354-3301 x263

Patient Name:

DOB:
HCN:
Address:

Phone/Cell #:

WSIB #: [Affix patient label here]

Physician Name: _____

Physician Signature: _____

Physician Contact #: _____

Date of Referral: _____

Report Copies To: _____

Message capable Physician phone # to receive same/next exam day urgent results:

_____ **(required)**

. INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .
PLEASE FAX COMPLETED REQUISITION TO 613-354-4331

☐ ER Patient in Hospital ☐ ER Patient Sent Home ☐ Inpatient/ICU ☐ CVC Outpatient ☐ Outpatient

CLINICAL INDICATION:

Requested date/time frame: _____
Note: DI Department triages requests based on provided history

P1 = Within 24hr
P2 = Within 48hr
P3 = Within 10 days
P4 = Within 28 days

ABDOMEN AND PELVIS
(no food/only water 6 hours prior & finish drinking 1L of water 1 hour before exam, full bladder)

☐ Abdomen and Pelvis
☐ Appendix
☐ KUB (fasting not required)

ABDOMEN
(no food/drink 6 hours prior)

☐ Abdomen
☐ Bariatric Pre-op
☐ Hepatoma Screening
☐ Portal Doppler
☐ Biliary / RUQ
☐ Gallbladder

No prep required:
☐ AAA
☐ Ascites
☐ Target to Organ:_____

VASCULAR

☐ Leg DVT ☐ RT ☐ LT
☐ Arm DVT ☐ RT ☐ LT

☐ Legs ABI Only
☐ Legs PVD Screen/ABI
☐ Arms PVD Screen
☐ Groin Aneurysm ☐ RT ☐ LT

☐ Carotid

HERNIA

Groin/Inguinal ☐ RT ☐ LT
☐ Abdominal Wall / Umbilical
Location:_____

MSK

Shoulder ☐ RT ☐ LT
Popliteal Fossa ☐ RT ☐ LT

PELVIS
(finish drinking 1L of water 1 hour before exam, full bladder)

☐ Pelvis ☐ Add PVR
☐ Add TV *if applicable*
☐ Bladder post void residual

FOCUSED ANATOMY

☐ Thyroid
☐ Neck lump
Location:_____
☐ Scrotal/Testicular

Appointment Date: **(DD/MM/YY) Time:** **Date Received:** **Date Notified:**