Lennox & Addington County General Hospital
DIAGNOSTIC IMAGING–
OBSTETRIC 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 ☐ CVC Outpatient ☐ Outpatient

CLINICAL INDICATION:

☐ Singleton
☐ Multiples

LMP:	**EDC:** ☐ **Based on LMP** ☐ **Based on dating US**

Requested date/time frame: _____

Note: DI Department triages requests based on provided history

P1 = Within 24hr **P3** = Within 10 days

P2 = Within 48hr **P4** = Within 28 days

1st & 2nd TRIMESTER *Prep: Finish drinking 1L water 1hr prior, full bladder*	**3rd TRIMESTER** *Prep: None*
☐ **COMPREHENSIVE NEW PREGNANCY ASSESSMENT**: • Dating Scan AND required follow ups **&** • Nuchal Translucency AND nasal bone confirmed **&** • Fetal Anatomy Survey AND follow-ups to completion https://www.prenatalscreeningontario.ca/en/pso/resources/Documents/NYGH-MMS-requisition.pdf **(complete & send with patient)**	☐ **BIOPHYSICAL = BPP, US GA, EFW, AFI +/- Cord Doppler** ▪ EFW done biweekly; Anatomy evaluated by request ▪ Cord Doppler done: SGA, IUGR, Oligohydramnios **Repeat Assessment on Following Dates**:
☐ Suspected Ectopic ○ Serum Beta HCG Level:_____ ➢ *Patient will be sent to ER post US (assessment and management). Please notify ER.*	☐ **GROWTH = US GA, EFW, AFI +/- Cord Doppler** ▪ EFW done biweekly; Anatomy evaluated by request ▪ Cord Doppler done: SGA, IUGR, Oligohydramnios **Repeat Assessment on Following Dates:**
☐ Early Pregnancy Well Being / Viability Check	
☐ Dating Scan AND required follow ups	☐ BPP only
☐ Nuchal Translucency AND nasal bone confirmed (11-14 wks) https://www.prenatalscreeningontario.ca/en/pso/resources/Documents/NYGH-MMS-requisition.pdf **(complete & send with patient)**	☐ Cervix Length only, to include TV assess <3cm length ☐ Placenta eval. only, to include TV assess <2cm from os
☐ Fetal Anatomy Survey(s) to completion	☐ Fetal Presentation only

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