Women's Ultrasound Clinic

Obstetrics & Gynecology

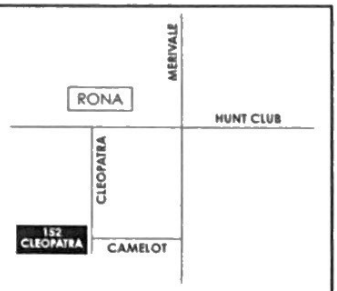
ULTRASOUND REQUISITION

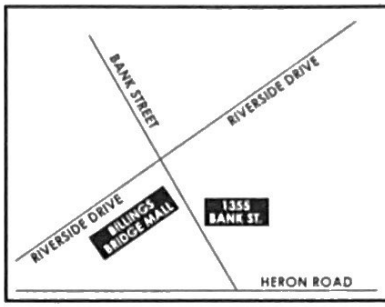
Appointment Date: _____

Time: _____

Please **Select** location, **Call** for appointment and **Fax** requisition

CLEOPATRA SITE
152 Cleopatra Drive
Suite 105
Ottawa, Ontario
K2G 5X2
Phone: 613-224-1166
Fax: 613-224-1916





BANK SITE
1355 Bank Street
Suite 203
Ottawa, Ontario
K1H 8K7
Phone: 613-728-2806
Fax: 613-728-6480

Patient's Name _____

Date Of Birth _____ (D/ M/ Y/) Telephone # _____ Medical Insurance # _____

Address _____

_____

Referring Physician _____ Referring Physician # _____

TEL# _____ FAX# _____

Referring Physician Address _____

This requisition can be taken to any licensed facility providing healthcare services including hospitals and IHF's.

PATIENT PREPARATION - GYNECOLOGICAL AND EARLY OBSTETRICAL
1 HOUR PRIOR TO ULTRASOUND EXAMINATION DRINK 4 - EIGHT OZ. GLASSES OF FLUID.
AFTER 28 WEEKS OF PREGNANCY 2 - EIGHT OZ. GLASSES OF FLUID.
Please arrive 10 minutes prior to your appointment

INDICATION:

OBSTETRICS: **L.M.P.:** _____ (D/ M/ Y/)

Dating _____ eFTS _____ Morphology _____ Growth _____ BPP _____ Level II Scan _____

History:

GYNECOLOGY: **L.M.P.:** _____ (D/ M/ Y/)

Pelvic _____ (Trans-Abd/Trans-Vaginal) Saline Infusion Sonohysterogram (S.I.S) _____ (endometrial saline infusion) Sono-Hystero-Salpingogram _____ (tubal patency test)

History:

This requisition form can be taken to any licensed facility providing health care services including hospitals accepting community referrals and community surgical and diagnostic centres, such as those listed on the website : Community surgical and diagnostic centres| ontario.ca