

ULTRASOUND REQUISITION FORM

Summerside Diagnostic Imaging Centre



107 Walker Ave, Summerside, PE C1N4K2

Phone: (902) 436-1119

Fax: (902) 436-0762

Email: info@summersideimaging.com

PATIENT INFORMATION	
Name:	Address:
Telephone:	Height and weight:
Date of Birth (YYYY/MM/DD):	HCN:

REFERRING PRACTITIONER	
Name:	Telephone:
Address:	Fax:

EXAM INFORMATION – Completed by referring practitioner	INDICATION FOR EXAM: Please provide all relevant history
<p>Requested ultrasound exam(s):</p> <p><input type="checkbox"/> Abdomen – Complete</p> <p><input type="checkbox"/> Abdomen – Limited (specify): _____</p> <p><input type="checkbox"/> Pelvic – Female <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transvaginal</p> <p><input type="checkbox"/> Pelvic – Male</p> <p><input type="checkbox"/> Obstetric (gestational age: _____ weeks)</p> <p><input type="checkbox"/> Renal / Kidneys</p> <p><input type="checkbox"/> Gallbladder</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Breast <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral</p> <p><input type="checkbox"/> Scrotum / Testes</p> <p><input type="checkbox"/> Soft Tissue / Lump / Hernia</p> <p><input type="checkbox"/> DVT Study <input type="checkbox"/> Upper <input type="checkbox"/> Lower Side: _____</p> <p><input type="checkbox"/> Carotid Doppler</p> <p><input type="checkbox"/> Other: _____</p>	

Practitioner signature:	Date:
--------------------------------	--------------

Forward copy of report to:	
Name:	Fax:

INTERNAL USE ONLY:	Appt date and time:
Ultrasound fee:	Accession #: