Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital
Partnering to keep healthcare close to home.

ULTRASOUND REQUISITION

☐ Alexandra Hospital Ingersoll (AHI)
AHI Scheduling/Bookings Contact:
Phone: 519-485-9611 Fax: 519-485-9601

☐ Tillsonburg District Memorial Hospital (TDMH)
TDMH Scheduling/Bookings Contact:
Phone: 519-842-6335 Fax: 519-842-4299

Referring Physician or Other Authorized Health Care Provider

Name (Please Print): _____

Phone: _____ Fax: _____

Provider Billing #: _____

Provider Signature: _____

Copy to: _____

Date of Referral: _____
(YYYY/MM/DD)

Patient Information:

Name (Last, First): _____

Date of Birth (DOB): _____ ☐ Male ☐ Female
YYYY MM DD

Personal Identification Number (PIN): _____

Address: _____

Phone Number (Home): _____

(Other): _____

Health Card Number: _____ Version Code: _____

☐ Workplace Safety & Insurance Board (WSIB)? (Please include approval for specific exam)

Claim #: _____

Date of injury (YYYY/MM/DD): _____

☐ 3rd Party or Insurance (Company or Self-pay): _____

Does this patient have special needs or impairments?

(Please specify): _____

☐ **Send to Emergency Department** ☐ **Send to Office**

Clinical Indication, History:

Examination(s) Requested:

ABDOMEN

- ☐ Abdominal wall (Hernia)
- ☐ Abdomen Complete
- ☐ Abdomen Limited (specify organ) _____
- ☐ Aorta
- ☐ Groin (Inguinal Hernia): ☐ Right ☐ Left
- ☐ Kidney
- ☐ Kidney and Bladder
- ☐ Male Pelvis

VASCULAR

Right	Left	
☐	☐	Arm Arteries (AHI only)
☐	☐	Arm Veins (Deep vein thrombosis (DVT))
☐	☐	Carotid Doppler (always bilateral)
☐	☐	Leg Arteries (AHI only)
☐	☐	Leg Veins (DVT)
☐	☐	Leg Veins (venous insufficiency - AHI only)

MUSCULOSKELETAL (MSK) AND SMALL PARTS

- ☐ Neck
- ☐ Thyroid
- ☐ Scrotum (Testicular)
- ☐ Soft Tissue Other (specify) _____
- ☐ Musculoskeletal (specify) _____

Right	Left	
☐	☐	Achilles
☐	☐	Knee (Bakers Cyst) ☐ Other: _____
☐	☐	Shoulder

TDMH ONLY:

- ☐ Thyroid Biopsy or Aspiration
- ☐ Lymph Node Biopsy

OBSTETRICS/GYNECOLOGY

Obstetrical (#): Gravida(G) ☐ Para (P) ☐ Abortus (A) ☐

Last Menstrual Period (LMP) (YYYY/MM/DD) _____

Estimated Date of Confinement (EDC) (YYYY/MM/DD) _____

- ☐ Obstetrical Dating
- ☐ Obstetrical Enhanced First Trimester Screen (eFTS) (TDMH only)
- ☐ Obstetrical Routine Anatomy (20 weeks)
- ☐ Obstetrical (High Risk excluding biophysical profile (BPP) and Fetal Doppler)
- ☐ Obstetrical Twins
- ☐ Female Pelvis ☐ Transvaginal (if indicated)

UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RETURNED AND APPOINTMENTS WILL NOT BE BOOKED UNTIL A SIGNED AND COMPLETED REQUISITION IS RECEIVED.