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: