Lennox & Addington County General Hospital
DIAGNOSTIC IMAGING–

GENERAL ULTRASOUND

Tel: 613-354-3301 x263

Patient Name:

DOB:
HCN:
Address:
Phone/Cell #:

☐ Non OHIP Patient:

☐ WSIB #:

Physician Name: _____

Physician Signature: _____

OHIP Billing Physician Name/#:_____

Physician Contact #: _____

Physician Fax #: _____

Date of Referral: _____

Report Copies To: _____

****Message capable Physician phone # to confirm receipt of urgent results:**

_____
**if absent, urgent result receipt confirmation delays may occur

. INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .
PLEASE FAX COMPLETED REQUISITION TO 613-354-4331

CLINICAL INDICATION:

Requested date/time frame:
Note: DI Department triages requests based on provided history

P1 = Within 24hr ***# required*
P2 = Within 48hr ***# required*
P3 = Within 10 days
P4 = Routine

ABDOMEN AND PELVIS
(no food/only water 6 hours prior & finish drinking 1L of water 1 hour before exam, full bladder)

☐ Abdomen and Pelvis
☐ Appendix
☐ KUB (fasting not required)

HERNIA

Groin/Inguinal ☐ RT ☐ LT

☐ Abdominal Wall / Umbilical
Location:_____

ABDOMEN
(no food/drink 6 hours prior)

☐ Abdomen
☐ Bariatric Pre-op
☐ Hepatoma Screening
☐ Portal Doppler
☐ Biliary / RUQ
☐ Gallbladder

No prep required:
☐ AAA
☐ Ascites
☐ Target to Organ:_____

VASCULAR

Leg DVT ☐ RT ☐ LT
Arm DVT ☐ RT ☐ LT

☐ Legs ABI Only
☐ Legs PVD Screen/ABI
☐ Arms PVD Screen

Groin Aneurysm ☐ RT ☐ LT

☐ Carotid

MSK

Shoulder ☐ RT ☐ LT
Popliteal Fossa ☐ RT ☐ LT
Knee ☐ RT ☐ LT
Achilles ☐ RT ☐ LT
Plantar Fascia ☐ RT ☐ LT

PELVIS
(finish drinking 1L of water 1 hour before exam, full bladder)

☐ Pelvis ☐ Add PVR

☐ Bladder only - PVR

FOCUSED ANATOMY

☐ Thyroid
☐ Neck lump
Location:_____

☐ Scrotal/Testicular

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