Lennox & Addington County General Hospital
DIAGNOSTIC IMAGING–

OBSTETRIC 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:

☐ NIPT=Bloodwork Req. not needed

EDC based on Dating US:_____

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

1st & 2nd TRIMESTER *Prep: Finish drinking 1L water 1hr prior, full bladder*	**3rd TRIMESTER** *Prep: None*
☐ **COMPREHENSIVE NEW PREGNANCY ASSESSMENT**: • Dating Scan AND required follow ups **&** • Nuchal Translucency AND nasal bone confirmed **&** https://www.prenatalscreeningontario.ca/en/pso/resources/Remediated-PDFs-2020/Common-MMS-requisition-FINAL-NYGH-V3-May-2022.pdf **(complete & send with patient unless NIPT)** • Fetal Anatomy Survey AND follow-ups to completion	☐ **GROWTH = US GA, EFW, AFI +/- Cord Doppler** ▪ EFW done biweekly; Anatomy evaluated by request ▪ Cord Doppler done: SGA, IUGR, Oligohydramnios Repeat Assessment on Following Dates:
☐ Suspected Ectopic ○ Serum Beta HCG Level:_____ ➢ *Patient will be sent to ER post US (assessment and management). Please notify ER.*	☐ **BIOPHYSICAL = BPP, US GA, EFW, AFI +/- Cord Doppler** ▪ EFW done biweekly; Anatomy evaluated by request ▪ Cord Doppler done: SGA, IUGR, Oligohydramnios Repeat Assessment on Following Dates:
☐ Early Pregnancy Well Being / Viability Check	
☐ Dating Scan AND required follow ups	☐ BPP only
☐ Nuchal Translucency AND nasal bone confirmed (11-14 wks) https://www.prenatalscreeningontario.ca/en/pso/resources/Remediated-PDFs-2020/Common-MMS-requisition-FINAL-NYGH-V3-May-2022.pdf **(complete & send with patient unless NIPT)**	☐ Cervix Length only, to include TV assess <3cm length ☐ Placenta Eval. only, to include TV assess <2cm from os
☐ Fetal Anatomy Survey(s) to completion	☐ Fetal Presentation only

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