Place Patient Form Label Here

ULTRASOUND REQUISITION (PHC)

* 7 8 7 2 *

Requisition Form

SPH: Tube to station 48
MSJ: Fax to 604-877-8132
Outpatient: Fax to 604-806-8524

☐ MSP ☐ WSBC
☐ ICBC ☐ Other

APPOINTMENT DATE: _____ **ARRIVAL TIME:** _____

Infection precautions: ☐ None
- ☐ Contact
- ☐ Droplet
- ☐ Airborn
- ☐ Airborne & Contact
- ☐ Droplet & Contact

Allergy/Intolerance Status:
Refer to completed Caution Sheet

Exam requested:
- ☐ Abdomen
- ☐ Aspiration/Biopsy
- ☐ Breast (MSJ only)
- ☐ Carotid
- ☐ Chest
- ☐ Extremity (*specify*)
- ☐ Miscellaneous
- ☐ Obstetrical
- ☐ Pelvic/Bladder
- ☐ Prostate (TRUS)
- ☐ Renal
- ☐ Scrotal
- ☐ Thyroid/Parathyroid
- ☐ Vascular (*specify)*

_____
_____

Reason for exam:

Relevant history:

Authorizing Physician: Date of request: _____

Additional copies of report to:

Printed name _____ Signature _____

College ID _____ Pager # _____