



**DEPARTMENT OF DIAGNOSTIC SERVICES
OUTPATIENT REQUISITION**

ST. CATHARINES GENERAL, ONTARIO STREET AND NIAGARA-ON-THE-LAKE SITES

<p>PLEASE SELECT THE APPROPRIATE SITE</p> <p><input type="checkbox"/> SCG Bookings (905) 378-4647 X46351 fax (905) 684-6990</p> <p><input type="checkbox"/> NTL Bookings (905) 378-4647 X46351 fax (905) 684-6990</p> <p><input type="checkbox"/> OSS Bookings (905) 378-4647 X63363 fax (905) 682-1602</p>	<p>NAME: _____</p> <p>DATE OF BIRTH: DAY ____/MONTH____/YR____</p> <p>HEALTH CARD # _____</p> <p>ADDRESS: _____</p> <p>_____</p> <p>WSIB. ACCIDENT: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CLAIM NUMBER: _____</p> <p>DATE: _____</p> <p>EMPLOYER: _____</p>
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*****INCOMPLETE REQUISITIONS WILL BE RETURNED TO PHYSICIAN'S OFFICE*****

X-RAY *To avoid irradiation during early pregnancy, abdominal and pelvic X-ray examinations should not be carried out in the second half of the menstrual cycle of women of child bearing age*

X-RAY EXAMINATION DESIRED (Preparations and conditions on back)

BONE DENSITOMETRY High Risk Date of Previous _____

ULTRASOUND & DOPPLER PROTOCOL: 1. URGENT 2. WITHIN A WEEK 3. ROUTINE

<p>ULTRASOUND</p> <p><input type="checkbox"/> Abdomen <input type="checkbox"/> Renal only</p> <p><input type="checkbox"/> Pelvis <input type="checkbox"/> Transvaginal</p> <p><input type="checkbox"/> Breast-----<input type="checkbox"/> R-----<input type="checkbox"/> L-----<input type="checkbox"/> Bilateral</p> <p><input type="checkbox"/> Thyroid <input type="checkbox"/> TRUS</p> <p><input type="checkbox"/> Scrotum</p> <p>Obstetrical</p> <p><input type="checkbox"/> Routine</p> <p><input type="checkbox"/> IPS (Nuchal Translucency)</p> <p><input type="checkbox"/> Obstetrical other _____</p> <p>LMP _____ E.D.C. _____</p>	<p>MUSCULOSKELETAL (MSK)</p> <p><input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Other _____</p> <p>Soft Tissue (effusion, cyst, ganglion, mass, etc)</p> <p>Area to be scanned: _____</p>	<p>DOPPLER</p> <p><input type="checkbox"/> Duplex Carotid Doppler</p> <p>Segmental Pressures (PVD, claudication, circulation)</p> <p><input type="checkbox"/> Lower Limbs</p> <p><input type="checkbox"/> Upper Limbs</p> <p><input type="checkbox"/> Duplex Venous Doppler</p> <p><input type="checkbox"/> Duplex Arterial Doppler</p> <p><input type="checkbox"/> Vein Mapping <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Other _____</p>
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PROPER PREPARATION IS IMPORTANT TO COMPLETE EXAMINATION, OTHERWISE RESCHEDULING MAY BE NECESSARY

<p>RELEVANT CLINICAL HISTORY:</p> <p>_____</p> <p>_____</p>	<p>ALLERGY HISTORY:</p> <p><input type="checkbox"/> NEG. <input type="checkbox"/> POSITIVE</p> <p>If positive, Describe:</p> <p>_____</p>
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APPOINTMENT DATE: DAY MONTH YEAR TIME: _____ hrs

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