

Medical Imaging Ultrasound Requisition

FOR MI OFFICE USE ONLY

Exam Date: _____

Arrival Time: _____

Exam Time: _____

<http://bit.ly/2ucQCPA>

**St. Michael's Hospital
Medical Imaging**
30 Bond Street, Toronto, ON, M5B 1W8
3rd Floor, Cardinal Carter Wing
Phone: 416-864-5885
Fax: 416-864-3051

**Sumac Creek Health Centre
St. Michael's Hospital**
73 Regent Park Blvd, Toronto, ON,
M5A 2B7 - 3rd Floor
Phone: 416-864-6060 ext.76840
Fax: 416-864-6051

**No site preference,
next available
appointment**
Phone: 416-864-5885
Fax: 416-864-3051

A. PATIENT INFORMATION	
MRN	DOB <i>YYYY/MM/DD</i>
Health Card #: _____ Version code: _____	
Last Name	<input type="checkbox"/> Self Pay <input type="checkbox"/> IFH <input type="checkbox"/> WSIB Claim # _____
First Name	<input type="checkbox"/> Female
Street Address	<input type="checkbox"/> Male
City	<input type="checkbox"/> Transgender - Female to Male
Postal Code	<input type="checkbox"/> Transgender - Male to Female
Province	<input type="checkbox"/> Intersex
Country	<input type="checkbox"/> Please Specify _____
<input type="checkbox"/> Interpreter: Language _____	Patient Consents to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Restricted Mobility, please describe needs _____	
<input type="checkbox"/> Isolation _____	
MOBILE: _____	
HOME: _____	
WORK: _____	

B. EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUESTS WILL BE RETURNED**

DATE OF REQUEST *YYYY/MM/DD*

EXAM REQUESTED

CLINICAL INFORMATION

LMP (please include for pelvic and obstetrical requests) _____

C. ST. MICHAEL'S HOSPITAL ULTRASOUND SERVICES	SUMAC CREEK ULTRASOUND SERVICES
ABDOMEN PELVIS (TV) RENAL TRANSPLANT OBSTETRICAL – dating only VASCULAR – lower extremity DVT MSK AND SOFT TISSUE – all types THYROID, FACE/NECK SCROTUM, TRUS	SONOHYSTEROGRAM (including tubal patency) THYROID, FACE/NECK FNA PROSTATE BIOPSY
ABDOMEN PELVIS (TV) RENAL TRANSPLANT OBSTETRICAL US - dating, NT, Level 1 anatomical scan, BPP VASCULAR US - lower extremity DVT, carotid Doppler, lower extremity arterial Doppler MSK AND SOFT TISSUE THYROID, FACE/NECK, SCROTUM	

D. ORDERING PHYSICIAN INFORMATION & SIGNATURE

Ordering Physician Name (please print):		<i>REQUIRED</i>	Copy to (please print):
Signature: <i>REQUIRED</i>	CPSO #:	Billing #:	
Date: <i>YYYY/MM/DD</i>	Phone #:	Fax #:	