



**OBSTETRICAL ULTRASOUND CLINIC
MATERNAL FETAL MEDICINE CLINIC
REQUISITION FORM**

**Schedule an Appointment: T: 519-672-7900 F: 519-672-8731
Monday to Friday 8:00am - 4:45pm
For all other inquiries and image requests call: 519-672-5270**

*All images available to Clinicians via the LXA Clinician's Portal and the Regional Diagnostic Imaging Repository.

Referral Date: _____

PATIENT INFORMATION

Requisition valid for 3 months after date issued

Name: _____

DOB: _____ Weight: _____ lbs/kgs

Phone Res: _____ Work: _____ Cell: _____

Health Card #: _____ Version Code

BY APPOINTMENT AT 450 CENTRAL ONLY

Please arrive 10 minutes early. Bring your health card and this form to your appointment. Late arrival and/or no form may require re-booking.

Date: _____ Time: _____

Location: _____

If you are unable to keep this appointment, please give at least 24 hours notice. Call 519-672-7900.

PHYSICIAN (required)

Referred By: _____ M.D.

Physician Address: _____

Billing #: _____ CC: _____

Physician Signature: _____

History/Clinical Findings (required)

STAT Call STAT Fax

ULTRASOUND (weight limit 350lbs) A full bladder is necessary for a complete and proper exam.

Singleton Twins Unknown Parity

LMP ____/____/____ (d/m/y) EDD ____/____/____ (d/m/y)

Clinical Information

Parity: G ____ P ____ A ____

Smoker: Yes No

Diabetic: Yes No

Hypertension: Yes No

Leaking: Yes No

Bleeding: Yes No

Pelvic Surgery: Yes No

Medications: Yes No

If yes to any of the above, please specify below.

MFM Consult: Yes No

Dating

Viability

Enhanced First Trimester Screen (EFTS)

1st Trimester Extended (early anatomy/EFTS)

Routine Anatomy 18-22 weeks

Cervical length (TV as required)

Recheck:

Growth Fetal Position

Placenta Assessment Amniotic Fluid

Doppler (Fetal Anemia/IUGR):

MCA/Umbilical Artery Ductus Venosus

Uterine Artery

Morphologic Recheck: Specify _____

Other _____

Biophysical Profile:

with NST with Doppler with NST & Doppler

NST

Fetal Echo (20-22 weeks)

OBSTETRICAL ULTRASOUND PREPARATION

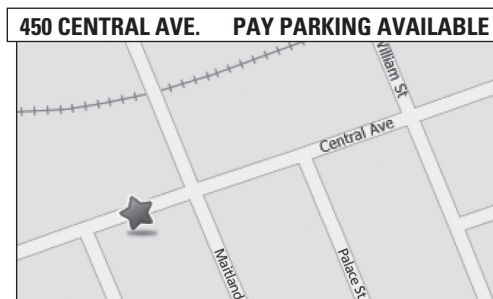
These instructions are **IMPORTANT**. Please follow them.

PREPARATION

A full bladder is necessary for a complete and proper exam. Do not empty your bladder. Your bladder must be full. **FINISH** drinking 4, eight ounce (250ml) glasses of water **at least 1 hour** prior to exam time. There are no eating restrictions for this test.

**FAILURE TO COMPLY WITH THE ABOVE OUTLINED PREPARATION INSTRUCTIONS
MAY RESULT IN THE EXAMINATION HAVING TO BE RESCHEDULED.**

TO MAKE APPOINTMENTS CALL OUR **BOOKINGS DEPARTMENT**
MONDAY TO FRIDAY BETWEEN 8:00 A.M. TO 4:45 P.M.
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FOR ALL OTHER INQUIRIES CALL 519-672-5270



This requisition form can be taken to any licensed facility providing healthcare services, including independent health facilities (IHF) and hospitals, such as those listed on the IHF Program website (<http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx>).

VISIT OUR WEBSITE: www.lxa.on.ca