

**Satellite X-Ray and Ultrasound Clinic**  
Georgina Health Centre  
716 The Queensway South  
Keswick ON, L4P 4C9

Health Record #: \_\_\_\_\_ Complete or place barcoded patient label here  
 Patient Name: *(Print first, last)* \_\_\_\_\_  
 DOB: mm / dd / yy Age: \_\_\_\_\_  Female  Male  
 OHIP #: \_\_\_\_\_ Version Code: \_\_\_\_\_  
 Phone #: \_\_\_\_\_

## Radiography and Ultrasound Imaging Requisition

*(see location map on reverse)*

<b>Patient Name:</b> <i>(print first, last)</i> _____		<b>Appointment Date:</b> <u>mm</u> / <u>dd</u> / <u>yy</u>	
<b>Address:</b> _____		<b>Appointment Time:</b> _____	
_____	Street Number + Name	_____	Apartment
_____	City	_____	Postal Code
<b>Health Card Number:</b> _____		<b>Version Code:</b> _____	
<b>Other Insurance:</b> _____		<b>WSIB Number:</b> _____	
<b>Home:</b> ( ) _____		<b>Work/Other:</b> ( ) _____	
<b>Date of Birth:</b> <u>mm</u> / <u>dd</u> / <u>yy</u>		<b>Hospital Record #:</b> _____	
<b>Patient Weight:</b> _____		<b>kg</b>	
<b>Patient not available:</b> From: <u>mm</u> / <u>dd</u> / <u>yy</u> To: <u>mm</u> / <u>dd</u> / <u>yy</u> Reason: _____			

### RADIOGRAPHY

**Exam(s) Requested:** *(all parts to be examined)*

**RELEVANT CLINICAL INFORMATION:** *(must be provided and please be specific)*

**Pregnant:**  Yes  No **LMP:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### ULTRASOUND

**PLEASE CHECK (✓) PROCEDURE REQUESTED:**

**ABDOMEN/PELVIC**

- Abdomen
- Female Pelvis/Endovaginal
- Male Pelvis (Pre & Post Void/Prostate)

**OTHER**

- Thyroid
- Scrotum
- Soft Tissue

**OBSTETRICAL**

- Dating
- Viability
- NT (11-13+6 weeks). Bring blood requisition
- Routine Anatomy (18-20 weeks)
- Obstetrical
- Biophysical Profile (>30 weeks)
- Twins
- Endovaginal (e.g. Cervical length)

**RELEVANT CLINICAL INFORMATION:** *(must be provided and please be specific)*

**Please fax completed and signed requisition to 905-535-1429**

**PATIENT PREPARATIONS AND INSTRUCTIONS ON REVERSE SIDE.**

**PHYSICIANS PLEASE CHECK APPROPRIATE BOX INDICATING PATIENT PREPARATION INSTRUCTIONS.**

<b>Referring Physician:</b> <i>(print first, last)</i> _____	<b>Date:</b> <u>mm</u> / <u>dd</u> / <u>yy</u>
<b>Signature:</b> _____	<b>Office Phone:</b> ( ) _____
<b>Address:</b> _____	<b>Fax Number:</b> ( ) _____



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## ***Patient Preparation and Information***

**The following ultrasound exams are done at Southlake Regional Health Centre:**

Arterial Arm Doppler, Arterial Leg Doppler, Breast, Carotid Doppler, Infant Head, MSK, and Shoulder.

**To book an appointment at Southlake Regional Health Centre, fax completed requisitions to 905-830-5966.**

### **PATIENT PREPARATION:**

**Obstetrical/Pelvic Examinations:**

A **full** bladder is required for this examination. **Finish drinking 4 large glasses** (32 oz/950ml) of clear fluid (water, coffee, juice, tea – no milk) **1 hour before** your appointment time. **Do Not Void** until after the examination is finished. This examination usually takes 30 minutes.

**Upper Abdomen Examination: (Liver, Pancreas, Gall bladder, Kidneys, Spleen, Aorta, Biliary Tree, Lymph Nodes)**

Please **do not eat or drink** for 12 hours before your appointment time. This examination usually takes 30 to 45 minutes. For children under 6 years of age: no preparation required.

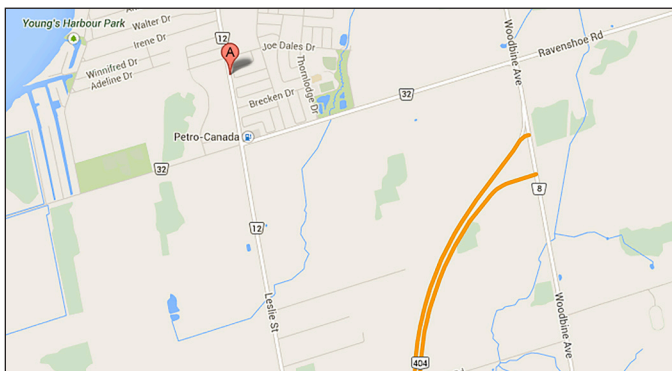
**Combination Examinations: Abdomen + Pelvis/Obstetrical**

A **full** bladder is required for this examination. Please **do not eat** for 12 hours before your appointment **but finish drinking 4 large glasses** (32 oz/950ml) of clear fluid (water, coffee, juice, tea – no milk) **1 hour before** your appointment time. **Do Not Void** until instructed by the technologist during the examination. The entire examination usually takes 1 hour.

**Other Ultrasound:** No preparation required.

### **PATIENT INFORMATION:**

- **Bring your Ontario Health Card.**
- **Bring this requisition. Diagnostic Imaging cannot perform any procedures without a requisition signed by a Physician or Nurse Practitioner.**
- If you are unable to keep your appointment, please call the Booking Department at 905-535-6000.



### **Location Map**

Georgina Health Centre  
716 The Queensway South  
Keswick ON, L4P 4C99

Bookings Phone: 905-535-6000  
Fax: 905-535-1429  
Email: [info@georginahealthcentre.ca](mailto:info@georginahealthcentre.ca)  
[www.georginahealthcentre.ca](http://www.georginahealthcentre.ca)

