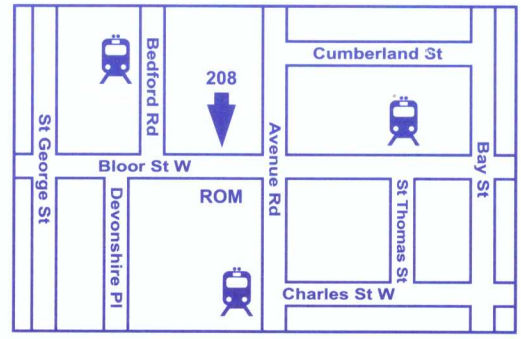
TORONTO ULTRASOUND IMAGING & CARDIOVASCULAR LABORATORY

208 BLOOR STREET WEST, SUITE 711
TORONTO,ON, M5S 3B4
TEL: 416-921-1333
FAX: 416-921-0444

- Walk-in welcome
  Mon-Fri 8:00am-7:00pm
- Open on **Saturdays** (by appointment)
- Visit Our Website at www.torontoultrasound.ca



Patient's Name:_____ Referred by:_____

Phone:_____ OHIP:_____ ❑ Walk-In ❑ Appointment:_____

Clinical Information: _____

_____

PLEASE BRING YOUR HEALTH CARD AND THIS REQUISITION FORM

ULTRASOUND EXAMINATIONS

❑ **Abdomen**	Nothing to eat or drink 8 hours prior to examination
❑ **Kidney** ❑ **Male Pelvis** ❑ **Bladder**	Drink 5 glasses of water 1 hour before examination. **DO NOT VOID (urinate)** until the examination is completed
❑ **Transrectal**	Purchase **FLEET ENEMA** from the pharmacy. Follow the instruction in the package. Take the enema 2 hours before the appointment time.
❑ **Female Pelvis** ❑ **Nuchal Translucency-IPS** ❑ **Transvaginal** ❑ **BPP** ❑ **Obstetrical < 16 wks.** ❑ **Doppler** ❑ **Obstetrical > 16 wks.** ❑ **Fetal Position**	Drink 5 glasses of water (35 - 40 oz). To be finished one hour before the test. **DO NOT VOID**

❑ **Breast** [R] [L] ❑ **Chest Masses** ❑ **Aorta (AAA)**
❑ **Thyroid** ❑ **Neck** ❑ **Parotid & Submandibular Glands**
❑ **Testicular** ❑ **Inguinal area** [R] [L] ❑ **Other Soft Tissue**

MUSCULOSKELETAL

[R] [L] **Shoulder**	[R] [L] **Thigh**	[R] [L] **Axilla**
[R] [L] **Knee**	[R] [L] **Hip Joint**	[R] [L] **Hamstring & Gluteal area**
[R] [L] **Hip**	[R] [L] **Carpal Tunnel**	[R] [L] **Calf**
[R] [L] **Wrists & Hands**	[R] [L] **Forearm Muscles**	[R] [L] **Other Musculoskeletal**
[R] [L] **Elbow**	[R] [L] **Achilles Tendons**	_____
[R] [L] **Ankle**	[R] [L] **Plantar Fascia**	_____
[R] [L] **Foot**		

VASCULAR

❑ **ARTERIAL DUPLEX:**
- ❑ **Lower Extremities (Incl. Aorta, ABI)**
- ❑ **Upper Extremities**

❑ **CAROTID DUPLEX**
❑ **ECHOCARDIOGRAPHY (2D & Colour Doppler)**
❑ **Holter Monitoring** ❑ **48 HRS.** ❑ **72 HRS.**

❑ **VENOUS DUPLEX: (R/O DVT, Venous Insufficiency/Reflux)**
- ❑ **Lower Extremities (Incl. iliac veins, IVC)**
- ❑ **Upper Extremities**

❑ **AORTIC SCREENING for ANEURYSM**
❑ **OTHER** _____
_____

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