



Toronto Ultrasound Imaging

180 Bloor St. W, Unit 204 - Toronto, ON M5S 2V6

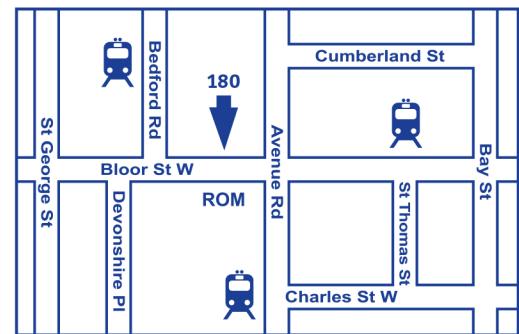
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email: 180torontoultrasound@gmail.com

web: torontoultrasound.ca

Please book an appointment by phone, fax or email.

Check our website torontoultrasound.ca for more information.



Patient's Name: _____ Referred by: _____

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

Clinical Information: _____

PLEASE BRING YOUR HEALTH CARD AND THIS REQUISITION FORM		
ULTRASOUND EXAMINATIONS		
<input type="checkbox"/> Abdomen	Nothing to eat or drink 8 hours prior to examination	
<input type="checkbox"/> Kidney	Drink 5 glasses of water 1 hour before examination.	
<input type="checkbox"/> Bladder	DO NOT VOID (urinate) until the examination is completed	
<input type="checkbox"/> Transrectal	Purchase FLEET ENEMA from the pharmacy. Follow the instruction in the package. Take the enema 2 hours before the appointment time.	
<input type="checkbox"/> Female Pelvis	<input type="checkbox"/> Nuchal Translucency-IPS	Drink 5 glasses of water (35 - 40 oz). To be finished one hour before the test.
<input type="checkbox"/> Transvaginal	<input type="checkbox"/> BPP	DO NOT VOID
<input type="checkbox"/> Obstetrical < 16 wks.	<input type="checkbox"/> Doppler	
<input type="checkbox"/> Obstetrical > 16 wks.	<input type="checkbox"/> Fetal Position	
<input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Chest Masses	<input type="checkbox"/> Aorta (AAA)
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Neck	<input type="checkbox"/> Parotid & Submandibular Glands
<input type="checkbox"/> Testicular	<input type="checkbox"/> Inguinal area <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Other Soft Tissue
MUSCULOSKELETAL		
<input type="checkbox"/> R <input type="checkbox"/> L Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L Thigh	<input type="checkbox"/> R <input type="checkbox"/> L Axilla
<input type="checkbox"/> R <input type="checkbox"/> L Knee	<input type="checkbox"/> R <input type="checkbox"/> L Hip Joint	<input type="checkbox"/> R <input type="checkbox"/> L Hamstring & Gluteal area
<input type="checkbox"/> R <input type="checkbox"/> L Hip	<input type="checkbox"/> R <input type="checkbox"/> L Carpal Tunnel	<input type="checkbox"/> R <input type="checkbox"/> L Calf
<input type="checkbox"/> R <input type="checkbox"/> L Wrists & Hands	<input type="checkbox"/> R <input type="checkbox"/> L Forearm Muscles	<input type="checkbox"/> R <input type="checkbox"/> L Other Musculoskeletal
<input type="checkbox"/> R <input type="checkbox"/> L Elbow	<input type="checkbox"/> R <input type="checkbox"/> L Achilles Tendons	_____
<input type="checkbox"/> R <input type="checkbox"/> L Ankle	<input type="checkbox"/> R <input type="checkbox"/> L Plantar Fascia	_____
<input type="checkbox"/> R <input type="checkbox"/> L Foot		
<input type="checkbox"/> 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>.