DO NOT WRITE IN THIS AREA - FOR RMH OFFICE USE ONLY

ULTRASOUND DEPARTMENT
10 Angeline St. N., Lindsay, K9V 4M8
Bookings **(705) 328-6110**
Fax **(705) 328-6188**

*** ***OUR DEPARTMENT WILL NEED*** ***
1. Your RMH red hospital card
2. Your Ontario Health card
3. This form (Contains information pertaining to your exam)

APPOINTMENT DATE: _____ TIME: _____ EXAM #

PATIENT **NAME**: _____ **A.N.D.** ☐ YES ☐ NO EXT. _____

PATIENT **PHONE #:** _____ **DOB:** _____

REFERRING **DOCTOR:** _____

PHONE #: _____

FAMILY **DOCTOR:** _____

☐ **URGENT ER/IP**
☐ **< 7 DAYS**
☐ **> 7 DAYS**
Discharged/ admitted

Do you have an accessibility concern?
YES ☐ **NO** ☐
Call us!

ISOLATION: ☐ YES ☐ NO **ISOLATION PRECAUTIONS:** ☐AIRBORNE ☐DROPLET ☐CONTACT ☐DROPLET/CONTACT

REASON FOR EXAM:

PHYSICIAN'S SIGNATURE: _____/___/___ (Day/Month/Year)

ALL OF THE ABOVE MUST BE COMPLETED AND SIGNED BY THE ORDERING PHYSICIAN

☐ **ABDOMEN**- Gallbladder, Kidneys, Aorta, Liver, Spleen, Pancreas

NOTHING to eat or drink for 8-10 hours before exam.

Medication may be taken with small amount of water.

☐ **KIDNEYS** - No Preparation Needed

☐ **GU** – includes: Kidneys Ureters, Bladder, Prostate

*** **DRINK 20oz (560 ml)** of water **FINISHING 1 Hour PRIOR** to appointment, Do not urinate. Patient may eat as normal.

OBSTETRICAL- LMP ___/___/___ (Day/Month/Year)

☐ **< 12 weeks** - 32 oz (1000 ml) water

☐ **18-20 weeks** anatomical scan - 32 oz (1000 ml) water

☐ **Biophysical Profile** - 20 oz (560ml) water

☐ **High Risk** - 20 oz (560ml) water, specify concern

*** **DRINK appropriate amount of water (as listed above), FINISHING 1 Hour PRIOR** to appointment.
Do not urinate. Patient may eat as normal.

☐ **FEMALE PELVIC**- UTERUS, OVARIES, BLADDER, ADNEXA

☐ **ENDOVAG**

☐ **MALE PELVIC**- BLADDER, PROSTATE

***DRINK 30oz (1000 ml)** of water **FINISHING 1 Hour PRIOR** to appointment. Do not urinate. Patient may eat as normal.
***If for **ABDOMINAL ULTRASOUND** as well, do **NOT eat 8-10 hours before exam**.

*** **NO PREPARATION NEEDED FOR ANY EXAMS LISTED BELOW.**

☐ **Venous Leg Doppler for DVT** ☐ Right ☐ Left

☐ **Carotid Ultrasound**

Other:

☐ Groin	☐ Right ☐ Left
☐ Breasts	☐ Right ☐ Left
☐ Shoulders (Rotator Cuff)	☐ Right ☐ Left
☐ Hips (paediatric)	☐ Right ☐ Left
☐ Knee	☐ Right ☐ Left
☐ Skull	☐ Thyroid
☐ Scrotum	☐Soft Tissue_____
☐Other:	

***IF PATIENTS ARE PROPERLY PREPARED,** EACH EXAM MAY TAKE UP TO 1 HOUR.

** NON-AMBULATORY PATIENTS MUST ARRIVE BY STRETCHER**

PLEASE FOLLOW PREPARATION INSTRUCTIONS CAREFULLY.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT,

PLEASE CALL (705) 328-6110 AS FAR IN ADVANCE AS POSSIBLE

AS WE HAVE A WAITING LIST AND EMERGENCIES.

IF YOU ARE LATE FOR YOUR APPOINTMENT, YOU MAY BE REBOOKED.

THANK YOU.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE

ULTRASOUND DEPARTMENT AT (705) 328-6110