# Diagnostic Imaging Ultrasound

William Osler Health System

Fax: 905-494-6614 ◯ Next available appointment **OR** ◯ Brampton Civic Hospital ◯ Etobicoke General Hospital ◯ Peel Memorial Centre

**Patient Information**

Name:_____ Date of Birth*(DD/MM/YYYY)*:_____
Health Card No:_____ Version Code:_____
Address:_____ City:_____ Prov.:_____ Postal Code:_____
Tel:_____ Email:_____

To **request DI exam for discharged ED / UCC patient**, select time frame* for DI exam, and send patient with this requisition to the DI remote / EDDI desk to book DI exam. **Do not fax this requisition.** ◯ Less than 24h ◯ Less than 48h ◯ Less than 10 days ◯ Less than 1 month

**Examination Requested** (***Procedures only done at BCH & EGH*)

**1. UPPER ABDOMEN (ABOVE UMBILICUS)**
☐ Complete Abdomen ☐ Renal only ☐ Liver only
☐ Gallbladder only ☐ Other
The following procedures are not covered by OHIP, and must be paid by patient prior to test:
☐ Abdomen with Liver Elastography
☐ Liver Elastography

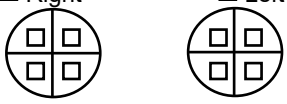
**2. PELVIS / LOWER ABDOMEN (BELOW UMBILICUS)**
☐ Female Pelvis ☐ Transvaginal ☐ Male Pelvis
☐ Scrotum ☐ Appendix
☐ Hernia
☐ TRP (Transrectal Prostate) **Requires SODIUM phosphates enema 2 hours prior**
☐ Other (Please specify) _____

**3. OBSTETRICS**
*Please note any OBS exam over 28 weeks must be booked at EGH or BCH*
☐ Early Dating Exam
☐ FTS (First Trimester Screening) – (eFTS, IPS)
☐ 18-20 Week Anatomical Assessment Exam
☐ Medically Indicated OBS Exam
☐ Biophysical Profile - Include Fetal Doppler
☐ EDC: _____

**4. Superficial Structures**
☐ Thyroid / Parathyroid
☐ Parotid gland & Submandibular gland
☐ Chest for Pleural Effusion
☐ Soft Tissue Mass, Specify area: _____

**5. Infant****
☐ Pediatric Brain
☐ Pediatric Spine
☐ Pediatric Hips

**6. Breast****
☐ Right ☐ Left



***Procedures only done at BCH & EGH*

**7. MSK (Focused exams targeted to answer clinical question)**
Shoulder ☐ Rt ☐ Lt Knee ☐ Rt ☐ Lt
Elbow ☐ Rt ☐ Lt Ankle ☐ Rt ☐ Lt
Wrist ☐ Rt ☐ Lt Hip ☐ Rt ☐ Lt
Digit (Specify) _____ ☐ Rt ☐ Lt

**8. Vascular (Refer to VASCULAR LAB requisition)**
☐ Carotid and Vertebral
☐ Venous - Upper Limbs ☐ Rt Arm ☐ Lt Arm
☐ Venous - Lower Limbs ☐ Rt Leg ☐ Lt Leg
**Note**: this exam does not include calf veins; if calf veins are to be examined, please refer to the VASCULAR LAB requisition
☐ Liver Doppler ☐ Aorta only
☐ Other (please specify) _____

**9. INTERVENTION****
Is patient on any anticoagulants/antiplatelets? ◯ Y ◯ N
If YES specify name(s): _____
Medically safe to stop anticoagulant/antiplatelets prior to procedure: ◯ Y ◯ N
☐ Fine Needle Aspiration ☐ Core Biopsy
Specify area:
_____
☐ Thoracentesis: ◯ Mark X (clinical guidance) ◯ Diagnostic ◯ Therapeutic
☐ Paracentesis: ◯ Mark X (clinical guidance) ◯ Diagnostic ◯ Therapeutic
Has this procedure been attempted clinically at bedside? ◯ Y ◯ N
☐ Transrectal Prostate Biopsy – It is the responsibility of the ordering Provider to instruct patient on preparation prior to the biopsy.
**Requires SODIUM phosphates enema 2 hours prior**
**Requires antibiotics – Provider to prescribe and instruct patient**
**Prostate biopsy requires INR and complete CBC within 14 days**

**Clinical Questionnaire**
Clinical History (Mandatory):

Provider Name (Print): _____ CPSO/OHIP Billing #: _____
Telephone: _____ Fax: _____ Copies to (Provider Name): _____
Provider Signature: _____ Date: _____

***Booking date is dependent on appointment availability and radiologist supervised clinical triaging based on provided clinical history**
**NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING**
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