

DIAGNOSTIC IMAGING – ULTRASOUND

Huntsville District Memorial Hospital
100 Frank Miller Drive
Huntsville, ON, P1H 1H7
T: 705-789-2311 x2242
F: 705-788-1485

South Muskoka Memorial Hospital
75 Ann Street
Bracebridge, ON, P1L 2E4
T: 705-645-4404 x3112
F: 705-645-7567

PATIENT BOOKING LINE: 1-877-348-6264

Patient Demographics:

Name	Last	First
Address		
Home Phone () -		Other Phone () -
<input type="checkbox"/> Do not contact patient. Provide appointment date/time to referring provider.		
DOB YYYY / MM / DD		<input type="checkbox"/> Male <input type="checkbox"/> Female
OHIP		

Isolation Precautions: Contact Droplet/Contact Airborne

Special Instructions (mobility, communication, etc.): _____ Falls Risk Wheelchair req'd

Relevant Clinical History:

Examination preparation may be required WSIB claim #: _____

<input type="checkbox"/> Abdomen Complete <input type="checkbox"/> Abdomen (Limited) <input type="checkbox"/> Renal <input type="checkbox"/> AAA follow up <input type="checkbox"/> Specify: _____ _____	Obstetrical LMP: _____ EDD: _____ <input type="checkbox"/> Biophysical Profile <input type="checkbox"/> Routine/anatomy 20wks = wk of _____ <input type="checkbox"/> Follow up <input type="checkbox"/> Dating <input type="checkbox"/> eFTS / Nuchal translucency	<table style="width:100%;"> <tr> <td style="text-align:center;">R</td> <td style="text-align:center;">L</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Breast</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Shoulders</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Knees</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>MSK Specify: _____</td> </tr> <tr> <td></td> <td></td> <td>Other Specify: _____</td> </tr> </table>	R	L		<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	MSK Specify: _____			Other Specify: _____
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<input type="checkbox"/>	<input type="checkbox"/>	MSK Specify: _____																		
		Other Specify: _____																		

<input type="checkbox"/> Urinary Tract/KUB <input type="checkbox"/> Pre/Post Void Volume <input type="checkbox"/> Male Pelvis <input type="checkbox"/> Female Pelvis <input type="checkbox"/> Transvaginal	<table style="width:100%;"> <tr> <td style="text-align:center;">R</td> <td style="text-align:center;">L</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Arm Veins</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Leg Veins</td> </tr> </table> <input type="checkbox"/> Thyroid/Face/Neck <input type="checkbox"/> Testicles	R	L		<input type="checkbox"/>	<input type="checkbox"/>	Arm Veins	<input type="checkbox"/>	<input type="checkbox"/>	Leg Veins
R	L									
<input type="checkbox"/>	<input type="checkbox"/>	Arm Veins								
<input type="checkbox"/>	<input type="checkbox"/>	Leg Veins								

Referring Provider:	Signature:
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Copies to:	Date:	OHIP Billing #:
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These examinations must be booked; please fax requisition. Preparation will be given at time of booking.

<p><i>Incomplete:</i></p> <input type="checkbox"/> Patient Information <input type="checkbox"/> Clinical History <input type="checkbox"/> Exam Requested <input type="checkbox"/> Signature <input type="checkbox"/> Printed name/CPSO Refaxed to office _____	<p><i>Office use only:</i> <i>VERSION: September 2023</i></p>
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