ST. MICHAEL'S
UNITY HEALTH TORONTO

Medical Imaging Ultrasound Requisition

http://bit.ly/2ucQCPA

FOR MI OFFICE USE ONLY

Exam Date: _____

Arrival Time:_____

Exam Time: _____

☐ **St. Michael's Hospital**
Medical Imaging
30 Bond Street, Toronto, ON, M5B 1W8
3rd Floor, Cardinal Carter Wing
Phone: 416-864-5885
Fax: 416-864-3051

☐ **Sumac Creek Health Centre**
St. Michael's Hospital
73 Regent Park Blvd, Toronto, ON,
M5A 2B7 - 3rd Floor
Phone: 416-864-6060 ext.76840
Fax: 416-864-6051

☐ **No site preference, next available appointment**
Phone: 416-864-5885
Fax: 416-864-3051

A. PATIENT INFORMATION

MRN **DOB** *YYYY/MM/DD*

Last Name

First Name

Street Address

City **Postal Code**

Province **Country**

☐ **Interpreter: Language** _____

☐ **Restricted Mobility, please describe needs**

_____

☐ **Isolation** _____

Health Card #: _____ **Version code:** ____

☐ **Self Pay** ☐ **IFH** ☐ **WSIB Claim #** _____

☐ **Female**
☐ **Male**
☐ **Transgender - Female to Male**
☐ **Transgender - Male to Female**
☐ **Intersex**
☐ **Please Specify** _____

Patient Consents to leave message ☐ **Yes** ☐ **No**
MOBILE: _____
HOME: _____
WORK: _____

B. EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUESTS WILL BE RETURNED**

DATE OF REQUEST *YYYY/MM/DD*

EXAM REQUESTED

CLINICAL INFORMATION

LMP (please include for pelvic and obstetrical requests) _____

C. ST. MICHAEL'S HOSPITAL ULTRASOUND SERVICES

ABDOMEN
PELVIS (TV)
RENAL TRANSPLANT
OBSTETRICAL – dating only
VASCULAR – lower extremity DVT
MSK AND SOFT TISSUE – all types
THYROID, FACE/NECK
SCROTUM, TRUS
SONOHYSTEROGRAM (including tubal patency)
THYROID, FACE/NECK FNA
PROSTATE BIOPSY

SUMAC CREEK ULTRASOUND SERVICES

ABDOMEN
PELVIS (TV)
RENAL TRANSPLANT
OBSTETRICAL US - dating, NT, Level 1 anatomical scan, BPP
VASCULAR US - lower extremity DVT, carotid Doppler, lower extremity arterial Doppler
MSK AND SOFT TISSUE
THYROID, FACE/NECK, SCROTUM

D. ORDERING PHYSICIAN INFORMATION & SIGNATURE

Ordering Physician Name (please print): *REQUIRED*			***Copy to (please print):***
Signature: *REQUIRED*	***CPSO #:***	***Billing #:***	
Date: *YYYY/MM/DD*	***Phone #:***	***Fax #:***	

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