Brockville General Hospital

ULTRASOUND REQUISITION

PLEASE FAX COMPLETED REQ TO (855) 564-1878

As of August 2025

PATIENT INFORMATION

Last Name	First Name	Date of Birth	YYYY	MM	DD

Address	City	Postal Code

Phone	E-mail Address	Health Card Number	Ver Code

If WSIB – Claim # _____ **Date of Injury** (YYYY/MM/DD):_____/____/____

Clinical information

ULTRASOUND

Obstetrical
- ☐ Detailed OB Scan (21 weeks only)
- ☐ High Risk
- ☐ BPP
- ☐ EFW
- ☐ BPP + EFW
- ☐ R/O Ectopic
- ☐ Dating OBS

Breast
- ☐ Right Breast
- ☐ Left Breast
- ☐ Right Axilla
- ☐ Left Axilla

General
- ☐ Abdomen
- ☐ Abdomen/Pelvis
- ☐ Pelvic
- ☐ Pelvic +/- TV
- ☐ Renal
- ☐ Bladder/Prostate
- ☐ Pre / Post Void
- ☐ Groins/Hernias
- ☐ Thyroid/Neck
- ☐ Testicular

Vascular
- ☐ Carotids
- ☐ Right Venous Leg
- ☐ Left Venous Leg
- ☐ Right Venous Arm
- ☐ Left Venous Arm
- ☐ Screening ABI(Legs)

Musculo-Skeletal
- ☐ Right Shoulder/Rotator Cuff
- ☐ Left Shoulder/Rotator Cuff
- ☐ Right Knee/Baker's Cyst
- ☐ Left Knee/Baker's Cyst
- ☐ Right Achilles Tendon
- ☐ Left Achilles Tendon
- ☐ Right Breast Biopsy
- ☐ Left Breast Biopsy
- ☐ Lymph Nodes Location:_____
- ☐ Other:_____

CLINICIAN INFORMATION

Date of the Request (YYYY/MM/DD): _____/____/____

Requesting Clinician Name (PRINT First and Last Name)	Clinician Fax Number
Clinician Signature	Clinician Phone Number

REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE

Copy Report to (PRINT First and Last Name)	Copy to Fax Number

DIAGNOSTIC IMAGING USE ONLY

Ultrasound Coding **P1:**_____ **Within 24 Hours** **P2:**____ **Within 1 Week** **P3:**____ **Within 1 Month** **P4:**____ **Elective**

Date (YYYY/MM/DD): _____/____/____ Time: _____ Confirmed: _____