Providence HEALTH CARE

US **RADIOLOGY**

ULTRASOUND REQUISITION

SPH: Tube to station 48

MSJ: Fax to 604-877-8132

Outpatient: Fax to 604-806-8524

MR MISS MRS MS	Surname	First name
Permanent address		
Postal code	Cell phone	Home phone / Work phone
DOB	Age	Sex
Care Card Number (PHN)	☐ MSP ☐ ICBC	☐ WSBC ☐ Other

APPOINTMENT DATE: _____ **ARRIVAL TIME:** _____

Infection precautions: ☐ None
- ☐ Contact
- ☐ Droplet
- ☐ Airborne
- ☐ Airborne & Contact
- ☐ Droplet & Contact

Allergy/Intolerance Status:
Refer to completed Caution Sheet

Exam requested:
- ☐ Abdomen
- ☐ Aspiration/Biopsy
- ☐ Breast (MSJ only)
- ☐ Carotid
- ☐ Chest
- ☐ Extremity *(specify)*
- ☐ Miscellaneous
- ☐ Obstetrical
- ☐ Pelvic/Bladder
- ☐ Prostate (TRUS)
- ☐ Renal
- ☐ Scrotal
- ☐ Thyroid/Parathyroid
- ☐ Vascular *(specify)*

_____

_____

Reason for exam:

Relevant history:

Authorizing Physician: Date of request: _____ Additional copies of report to:

Printed name _____ Signature _____

College ID _____ Pager # _____