NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA

DEPARTMENT OF DIAGNOSTIC SERVICES
OUTPATIENT REQUISITION

ST. CATHARINES GENERAL, ONTARIO STREET AND NIAGARA-ON-THE-LAKE SITES

PLEASE SELECT THE APPROPRIATE SITE

- ☐ **SCG Bookings (905) 378-4647 X46351**
  fax (905) 684-6990
- ☐ **NTL Bookings (905) 378-4647 X46351**
  fax (905) 684-6990
- ☐ **OSS Bookings (905) 378-4647 X63363**
  fax (905) 682-1602

NAME: ____________________
DATE OF BIRTH: DAY ______/MONTH______/ YR_____
HEALTH CARD #____________________
ADDRESS: ____________________
____

WSIB. ACCIDENT: ☐YES ☐NO
CLAIM NUMBER: ____________________
DATE: ____________________
EMPLOYER: ____________________

**********INCOMPLETE REQUISITIONS WILL BE RETURNED TO PHYSICIAN'S OFFICE***********

X-RAY ***To avoid irradiation during early pregnancy, abdominal and pelvic X-ray examinations should not be carried out in the second half of the menstrual cycle of women of child bearing age***

X-RAY EXAMINATION DESIRED **(Preparations and conditions on back)**

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BONE DENSITOMETRY ☐High Risk Date of Previous____________________

ULTRASOUND & DOPPLER PROTOCOL: ☐1. URGENT ☐2. WITHIN A WEEK ☐3. ROUTINE

ULTRASOUND
- ☐Abdomen ☐Renal only
- ☐Pelvis ☐Transvaginal
- ☐Breast------☐R------☐L------☐Bilateral
- ☐Thyroid ☐TRUS
- ☐Scrotum

Obstetrical
- ☐Routine
- ☐IPS (Nuchal Translucency)
- ☐Obstetrical other____________________

LMP____________________ E.D.C. ____________________

MUSCULOSKELETAL (MSK)
- ☐Shoulder ☐ R ☐ L
- ☐Knee ☐ R ☐ L
- ☐Other____________________

Soft Tissue
(effusion, cyst, ganglion, mass, etc)
Area to be scanned:
____

DOPPLER
- ☐Duplex Carotid Doppler

Segmental Pressures
(PVD, claudication, circulation)
- ☐Lower Limbs
- ☐Upper Limbs

- ☐Duplex Venous Doppler
- ☐Duplex Arterial Doppler
- ☐Vein Mapping ☐R ☐L
- ☐Other ____________________

PROPER PREPARATION IS IMPORTANT TO COMPLETE EXAMINATION, OTHERWISE RESCHEDULING MAY BE NECESSARY

RELEVANT CLINICAL HISTORY:
____
____

ALLERGY HISTORY:
☐**NEG.** ☐**POSITIVE**
If positive, Describe:
____

APPOINTMENT DATE: **DAY** | **MONTH** | **YEAR** **TIME:** ____________ **hrs**

Form 900344 Rev. 11/2007

PHYSICIAN'S SIGNATURE:____________________