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)**

_____

_____

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:_____

13/Aug/2023 08:41