northern health
the northern way of caring

Facility
Facility Address
Facility Phone and Fax
Facility Day of Operations and Hours

Last Name:
First Name (Preferred Name):
Encounter number: NH Number: Chart Created: Y/N
Date of Birth: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:

PATIENT LABEL

Ultrasound Requisition

Department Use Only Requisition Received Date: Time:	Appointment Date: Time:

Important: "*" fields must be completed to avoid delays in patient processing.

Patient Information

Last Name*:	First Name*:	Personal Health Number*:
Address*:	City *: Province: Postal Code:	Date of Birth*: YYYY MM DD
Primary Phone*: Alternate Phone*:	Height (cm)*: Weight (kg)*: Gender:	Interpreter Required: ☐ No ☐ Yes Specify Language:

☐ _____(Name of delegate)_____ can book this appointment for the patient

Mobility Requirements: ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift ☐ Walk ☐ Stretcher ☐ Bed ☐ Bariatric

Bill To: ☐ MSP Insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other: _____ ICBC/WSBC Number:

Infection Concerns: ☐ VRE ☐ Active TB ☐ MRSA ☐ C.diff ☐ Other: _____

Isolation precautions:

☐ Outpatient ☐ Inpatient ☐ ER ☐ ICU ☐ Other: _____

Ordering clinician timeframe request: (**Note:** Medical Imaging department will review with the relevant clinical information provided using MoH guidelines to determine the priority for scheduling the patient.)

☐ P1: within 24 hours ☐ P2: 2 to 7 days ☐ P3: 8 to 30 days ☐ P4: 31 to 60 days ☐ P5: specific date/follow up: _____

MI reviewed Priority P _____ Initials _____

Exam Category: Note Echocardiography and Breast Imaging have separate requisitions.

☐ Abdominal/Pelvic ☐ Acute ☐ Chronic	☐ Gynecological ☐ Acute ☐ Chronic ☐ Post-Menopausal ☐ LNMP: _____	☐ Obstetrical ☐ LNMP: _____ ☐ BhCG: _____ ☐ EDD: _____	☐ MSK ☐ Acute ☐ Chronic	☐ Vascular ☐ D-Dimer: _____ ☐ GFR: _____ ☐ Date of Stroke/TIA: _____	☐ Pediatric less than 12 years of age

☐ Portable: Reason: _____

Exam Requested*: _____
_____
_____
Previous Relevant Exams: _____
Previous Centre: _____

Ordering clinician's name (print)*: _____
MSP #*: _____
Signature: _____
Copies to*: _____
Phone #*: _____ ☐ Urgent report requested

Clinical Findings / History / Clinical Question (must be legible)*:

Images: _____ **Cine:** _____ **Tech:** _____

northern health
the northern way of caring

Facility
Facility Address
Facility Phone and Fax
Facility Day of Operations and Hours

Last Name:
First Name (Preferred Name):
Encounter number: NH Number: Chart Created: Y/N
Date of Birth: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:

PATIENT LABEL

Ultrasound Requisition

FOR MEDICAL IMAGING USE ONLY:

MEDICAL IMAGING PRIORITIZATION AND COMMUNICATION

To be completed by Medical Imaging personnel:

☐ Radiologist required
Notes for booking staff:

To be completed by booking personnel:

Attempts to book:
1.

2.

3.

Notes:

Appointment date: _____ Time: _____

Place flashcard label here