northern health
the northern way of caring

All Sites and Facilities

Ultrasound Requisition

Last Name:
First Name (Preferred Name):
Encounter #: NH #: Chart Created: ☐ Yes ☐ No
DOB: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:
PATIENT LABEL

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:

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

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

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

☐ Outpatient ☐ Inpatient ☐ ER ☐ ICU ☐ Other:

Ordering clinician timeframe request: (**Note:** Medical Imaging department will review with the relevant clinical information provided using BC 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: _____ ☐ 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:** _____

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FOR MEDICAL IMAGING USE ONLY:

MEDICAL IMAGING PRIORITIZATION AND COMMUNICATION

Place flashcard label here

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: _____