DIAGNOSTIC IMAGING – OBSTETRICAL ULTRASOUND U/S

Quinte Health

	Provider Name:	Patient Name:
	Signature:	DOB:
	MD Phone:	HCN:
	Date (d/m/y):	Home Phone:
FAX ALL REQUISITIONS TO: **613-969-5561**	Copies to:	Cell Phone:
	WSIB #:	Address:

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:

G T P A L EDC (yyyy/mm/dd): based on: ◯ LMP ◯ T1US ◯ T2US ◯ **SINGLE** ◯ **MULTIPLE**

PRIORITY: ◯ Urgent ◯ Non-Urgent Specific date/Timeframe:

LOCATION: ◯ Outpatient ◯ ED Patient In Hospital ◯ Quinte 7/OAC ◯ Inpatient on ◯ ED/Q7 Callback

PREFERRED HOSPITAL: ◯ BGH ◯ TMH ◯ PEC ◯ NHH

OFFICE USE ONLY

Appointment Date(s) & Time(s):

1st and 2nd TRIMESTER:

Prep: finish drinking 1L of water 1hour prior, full bladder

1st TRIMESTER ◯ Dating ◯ Threatened Abortion ◯ Ectopic ◯ F/U study dated

Beta HCG Level: Date: (mm/dd)

2st TRIMESTER ◯ Fetal Anatomy Survey (18-22 weeks)

◯ Follow up of site(s) of interest:

Previous scan done at on date: (mm/dd)

◯ Cervical Length ☐ Single Assessment ☐ Weekly until weeks

3rd TRIMESTER: No Prep

NOTE: Umbilical Artery Dopplers/BPP performed if EFW <10%ile; EFW no more frequent than q2 weeks

SINGLE ASSESSMENT: ☐ EFW ☐ AFV ☐ BPP

MULTIPLE ASSESSMENTS: **Starting on** OR **at** weeks

◯ BPP **weekly**

◯ BPP **twice weekly**

◯ BPP **weekly** with EFW at **36 weeks**

◯ **Weekly** umbilical artery Dopplers + BPP with **q2week** addition of EFW

◯ **Twice weekly** umbilical artery Dopplers + BPP with **q2week** addition of EFW

OTHER:

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613-969-5561

LMP: Last Menstrual Period, T1US: First Trimester Ultrasound, T2US: Second Trimester Ultrasound; BPP: Biophysical Profile; EFW: Estimated Fetal Weight; AFV: Amniotic Fluid Volume