US Ultrasound (US) Requisition

Providence HEALTH CARE

☐ ST. PAUL'S HOSPITAL
1081 Burrard St., Vancouver, BC V6Z 1Y6
Phone: 604-806-8161 Fax: 604-806-8524

☐ MOUNT SAINT JOSEPH HOSPITAL
3080 Prince Edward Street,
Vancouver, BC V5T 3N4
Phone: 604-877-8323 Fax: 604-877-8132

MR MISS MRS MS	SURNAME	FIRST NAME	
PERMANENT ADDRESS			
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE
DATE OF BIRTH (MONTH / DAY / YEAR)		AGE	SEX
HEALTH CARE #	MSP ☐	WCB ☐	ICBC ☐ OTHER ☐

Appointment Date: _____ **Time:** _____

Infection Concerns

☐ Yes ☐ No

SPECIFY: _____

Exam Requested

- ☐ ABDOMEN
- ☐ ASPIRATION/BIOPSY
- ☐ CAROTID
- ☐ CHEST
- ☐ EXTREMITY
- ☐ MISCELLANEOUS
- ☐ OBSTETRICAL
- ☐ PELVIC/BLADDER
- ☐ PROSTATE
- ☐ RENAL
- ☐ SCROTAL
- ☐ THYROID/PARATHYROID
- ☐ VASCULAR

SPECIFY: _____

Exam Requested (MSJH Only)

☐ BREAST

Relevant Previous Exams?

☐ X-Ray ☐ CT ☐ U/S

DATE: _____

LOCATION: _____

Clinical Information

DATE	SIGNATURE OF AUTHORIZING PHYSICIAN

Please Print NAME

_____ Prac. No. _____

ADDITIONAL COPY OF REPORT TO: _____

Technical Impression

TECH	RAD