ULTRASOUND CLINIC

◯ **MELFORT**
1121 Main Street Mall | Melfort, SK S0E 1A0
p: 306 752 3166 **f:** 306 752 3167 **c:** 306 921 3107

◯ **HUMBOLDT**
2408 Westwood Centre | Humboldt, SK S0K 2A0
p: 306 682 3163 **f:** 306 682 3164 **c:** 306 231 6188

◯ **PRINCE ALBERT**
300-681 15th Street W | Prince Albert, SK S6V 7H9
p: 306 764 1986 **f:** 306 764 1978 **c:** 306 960 8862

PATIENT INFO

Patient Name: _____ Health #: _____

Address: _____ City: _____ Prov: _____ Postal: _____

◯ Male ◯ Female DOB: dd / mm / yyyy LMP: dd / mm / yyyy

Contact #'s Cell: _____ Work: _____ Home: _____

APPOINTMENT

**** NOTE **** We appreciate a **1-DAY NOTICE OF CANCELLATION OR RESCHEDULING**. All patients must be at the Clinic no later than 5 minutes prior to appointment time. **IF YOU BRING CHILDREN ALONG TO AN APPOINTMENT, PLEASE HAVE ANOTHER ADULT TO SUPERVISE.**

Date | Time

REQUISITION

☐ **WALK IN** ☐ **WHEELCHAIR** ☐ **STRETCHER**

- ☐ Abdomen Upper
- ☐ Pelvis or Lower Abdomen
- ☐ IUCD Position
- ☐ Abdominal Wall / Torso
- ☐ Renal & Bladder
- ☐ Appendix
- ☐ Hernia or Groin ☐ *Right* ☐ *Left*
- ☐ Soft Tissue
- ☐ Thyroid
- ☐ Testes
- ☐ Obstetric
  - ☐ Dating under 12w
  - ☐ Detail 20-22w (BMI_____or Weight_____lbs)
  - ☐ 3rd Trimester
    - ☐ *BPP* ☐ *RI* ☐ *Biometry*
- ☐ Venous Doppler
  - Leg ☐ *Right* ☐ *Left*
  - Arm ☐ *Right* ☐ *Left*
- ☐ Shoulder ☐ *Right* ☐ *Left*
- ☐ Knee ☐ *Right* ☐ *Left*
- ☐ Other _____

INDICATIONS

- ☐ **Non-Urgent**
- ☐ **Semi-Urgent** *(3-5 days)*
- ☐ **Urgent** *(1-2 days)*

Referring Physician _____ Signature _____

PLEASE SEND A COPY TO _____