LONDON X-RAY ASSOCIATES
EST.1931

OBSTETRICAL ULTRASOUND & MATERNAL FETAL MEDICINE CLINIC

TO MAKE AN APPOINTMENT CALL OUR BOOKINGS DEPARTMENT
OR VISIT WEBSITE www.lxa.on.ca
TEL: 519-672-7900 FAX: 519-672-8731
FOR ALL OTHER INQUIRIES AND IMAGE REQUESTS CALL 519-672-5270

*PLEASE COMPLETE ALL APPLICABLE FIELDS

PATIENT INFORMATION

Requisition valid for 6 months after date issued

*REFERRAL DATE: _____

*NAME: _____ *TELEPHONE: _____ *DOB: _____

*HEALTH CARD #: _____ *VERSION CODE: ☐ ☐

*WEIGHT: _____ LBS/KGS

APPOINTMENT DETAILS -

Please arrive 10 minutes early. Bring your health card and this form to your appointment. Late arrival and/or no form may require re-booking.
NOTE: Non confirmation of appointment will result in appointment being cancelled.

DATE: _____ TIME: _____ LOCATION: _____

If you are unable to keep this appointment, please give at least 24 hours notice. Call 519-672-7900

EXAM Preparations and MAPS on the back

ULTRASOUND

(WEIGHT LIMIT 350LBS) A FULL BLADDER IS NECESSARY FOR A COMPLETE AND PROPER EXAM.

❒ **Singleton** ❒ **Twins** ❒ **Unknown Parity**

LMP ____/____/____ (d/m/y) **EDD** ____/____/____ (d/m/y)

Clinical Information

Parity: G _____ P _____ A _____

High Risk: Yes ❒ No ❒

Smoker: Yes ❒ No ❒

Diabetic: Yes ❒ No ❒

Hypertension: Yes ❒ No ❒

Leaking: Yes ❒ No ❒

Bleeding: Yes ❒ No ❒

Pelvic Surgery: Yes ❒ No ❒

Medications: Yes ❒ No ❒

If yes to any of the above, please specify below.

_____

_____

_____

❒ **MFM Consult:** Yes ❒ No ❒

❒ Viability (6 weeks +)

❒ Dating (8-10 weeks) later, if no previous ultrasound

❒ Enhanced First Trimester Screen (EFTS)

❒ Routine Anatomy (18-22 weeks)

❒ Cervical Length (TV as required)

❒ Recheck:

- ❒ Growth - please specify _____
- ❒ Fetal Position
- ❒ Placenta Assessment ❒ Amniotic Fluid
- ❒ Doppler (Fetal Anemia/IUGR):
  - ❒ MCA/Umbilical Artery ❒ Ductus Venosus
  - ❒ Uterine Artery
- ❒ Morphologic Recheck: Specify _____

❒ Biophysical Profile:

❒ Fetal Echo (20-22 weeks)

PHYSICIAN (REQUIRED)

Referred By: _____ M.D.

Physician Address: _____

_____

Billing #: _____ CC: _____

Physician Signature: _____

History/Clinical Findings **(required)**

_____

_____

_____

❒ STAT Call ❒ STAT Fax

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REV. 070125

This requisition form can be taken to any licensed facility providing healthcare services, including Integrated Community Health Services Centres (ICHSCs) and hospitals, such as those listed on the Integrated Community Health Services Centres (ICHSCs) website (https://www.ontario.ca/page/community-surgical-and-diagnostic-centres#section-1).

OBSTETRICAL ULTRASOUND PREPARATION

These instructions are **IMPORTANT.** Please follow them.

PREPARATION

A full bladder is necessary for a complete and proper exam. Do not empty your bladder. Your bladder must be full.
FINISH drinking 4, eight ounce (250ml) glasses of water **at least 1 hour** prior to exam time.
There are no eating restrictions for this test.

FAILURE TO COMPLY WITH THE ABOVE OUTLINED PREPARATION INSTRUCTIONS MAY RESULT IN THE EXAMINATION HAVING TO BE RESCHEDULED.

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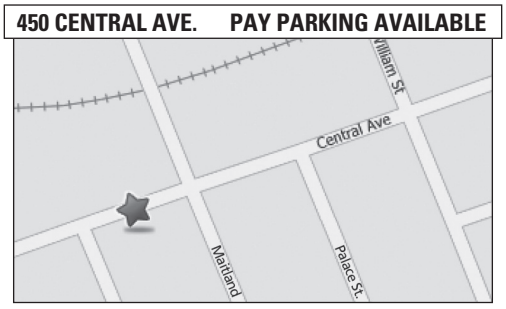

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