Patient Details     Name   Date of Birth     Address   Email Address   Phone Number   Healthcard Number   Version     Clinical notes / Indication     Clinical notes / Indication     Clinical notes / Indication     Previous imaging?   Yes   Yes   No   If yes, place include reports from previous 2 years for same issuedarea     Mesculoskeletal Ultrasound   Other Soft Toque:     Mesculoskeletal Ultrasound     Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Family physician (if different from referring doctor)        Eventore instructions	HAMILTON ULTRASOUN DIAGNOSTIC SERVICES		200 James St. South, Suite 305 Hamilton, ON L8P 3A9 Phone: (905) 522-2220 Fax: (905) 522-2280 www.hamiltonultrasound.ca
Address   Email Address   Phone Number   KeathCard Number   Version   Clinical notes / Indication   Previous imaging?    Yes   \text{ Yes   Yes   No   If yes, please indude reports from previous 2 years for same itsuefarea     Musculoskettal Ultrasound   Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Fax Number   Family physician (if different from referring doctor)	Patient Details		
Address Phone Number   Healthcard Number Version   Clinical notes / Indication Galibladder   Clinical notes / Indication Galibladder   Previous imaging? Imaginal area   Yes No   If yes, please indude reports from previous 2 years for same insurface   Referring physician or healthcare provider   Signature Date   Billing Number   Fax Number   Fax Number   Fax Number   Fax Number   Fax Number	Name	Date of Birth	
Email Address Phone Number   Healthcard Number Version   Clinical notes / Indication Galibiadser   Clinical notes / Indication Solean   Previous imaging? Imaginal area   Yes No   Hyes, please include reports from previous 2 years for same issuefarea   Referring physician or healthcare provider   Signature Date   Billing Number   Fax Number   Fax Number   Fax Number   Fax Number   Scan for patient instructions   Stan for patient instructions	Address		General
Email Address Phone Number   Healthcard Number Version   Clinical notes / Indication Galibladder   Clinical notes / Indication Galibladder   Previous imaging? Imaginal area   Yes No   If yes, please include reports from previous 2 years for same issuefarea   Other Soft Tissue:     Musculosketetal Ultrasound   Referring physician or healthcare provider   Signature Date   Billing Number   Fax Number   Fax Number   Fax Number   Fax Number   Fax Number			Abdomen (Full)
Healthcard Number Version   Clinical notes / Indication Spleen   Previous imaging? Previous imaging?   Yes No   If yes, please include reports from previous 2 years for same issue/area   Referring physician or healthcare provider   Signature   Date   Billing Number   Fax: Number			
Clinical notes / Indication   Clinical notes / Indication   Parcreas   Arra (AA)   Renal   Male Peblos   Inguinal area   R   L   Tryroid   Neck   Testicular   Previous imaging?   Yes   No   If yes, please include reports from previous 2 years for same issue/area     Musculoskeletal Ultrasound   R   L   Signature   Billing Number   Fax Number   Fax Number   Fax Number   Family physician (if different from referring doctor)	Email Address	Phone Number	_ Appendix
Clinical notes / Indication	Healthcard Number	Version	Gallbladder
Previous imaging?   Yes   No   If yes, please include reports from previous 2 years for same issue/area     Musculoskeletal Ultrasound   Chest Masses   Other Soft Tissue:     Musculoskeletal Ultrasound   Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Family physician (if different from referring doctor)     Sean for patient instructions			☐ Kidneys
Previous imaging?   Yes   No   Hyes, please include reports from previous 2 years for same issue/area     Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Fax Number   Fax Number   Fax Number   Family physician (if different from referring doctor)     Sean for patient instructions	Clinical notes / Indication		Spleen
Previous imaging?   Yes   Yes   No   If yes, please include reports from previous 2 years for same issue/area     Musculoskeletal Ultrasound   Chest Masses   Other Soft Tissue:     Musculoskeletal Ultrasound   Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions			Pancreas
Previous imaging?   Yes   No   If yes, please include reports from previous 2 years for same issue/area     Chest Masses   Chest Masses <t< td=""><td></td><td></td><td>Aorta (AAA)</td></t<>			Aorta (AAA)
Previous imaging?   Yes   Yes   No   If yes, please include reports from previous 2 years for same issue/area     Musculoskeletal Ultrasound   Chest Masses   Other Soft Tissue:     Musculoskeletal Ultrasound   Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions			Renal
Previous imaging?   ``Yes ``No ``If yes, please include reports from previous 2 years for same issue/area     Musculoskeletal Ultrasound   C   Referring physician or healthcare provider   Signature `Date   Billing Number   Fax Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions			Male Pelvis
Previous imaging?   \relation Yes   \velasion Yes			🗌 Inguinal area 🗌 R 🗌 L
Previous imaging?   \u00e9 Yes   \u00e9 Yes <td></td> <td></td> <td>Thyroid</td>			Thyroid
Previous imaging?   \u00e9 Yes   \u00e9 Yes <td></td> <td></td> <td>Neck</td>			Neck
Previous imaging?   ' Yes   No   If yes, please include reports from previous 2 years for same issue/area     Chest Masses   Other Soft Tissue:     Musculoskeletal Ultrasound   R   L   Signature   Date   Billing Number Fax Number Fax Number Family physician (if different from referring doctor)    Stan for patient instructions   Scan for patient instructions			Testicular
Previous imaging?   \vert ves   No   If yes, please include reports from previous 2 years for same issue/area     Chest Masses   Other Soft Tissue:     Musculoskeletal Ultrasound   R   L   Signature   Date   Billing Number Fax Number Fax Number Family physician (if different from referring doctor) Scan for patient instructions			Parotid & Submandibular
☐ Yes ☐ No If yes, please include reports from previous 2 years for same issue/area   ☐ Chest Masses   ☐ Other Soft Tissue:     Musculoskeletal Ultrasound   ☐ R ☐ L Shoulder     Billing Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions	Previous imaging?		Glands
Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Faxnumber   Family physician (if different from referring doctor)     Standard     Scan for patient instructions			Chest Masses
Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions			Other Soft Tissue:
Referring physician or healthcare provider   Signature   Date   Billing Number   Fax Number   Family physician (if different from referring doctor)   Scan for patient instructions			Musculoskeletal Ultrasound
Signature Date   Billing Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions			🗌 R 🗌 L Shoulder
Signature Date   Billing Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions			
Billing Number   Fax Number   Family physician (if different from referring doctor)     Scan for patient instructions	Referring physician or healthcar	re provider	
Fax Number         Family physician (if different from referring doctor)         Scan for patient instructions	Signature	Date	
Family physician (if different from referring doctor)       Scan for patient instructions	Billing Number		
Family physician (if different from referring doctor)	Fax Number		
This requisition form can be taken to any licensed facility providing healthrare services including hospitals and IHEs such as those listed on the	Family physician (if different fro	om referring doctor)	Scan for patient instructions
This requisition of the data water to any increase radius providing neutrical eservices including nospitals and they, such as those instead on the IHF Program website: http://www.health.gov.on.ca/en/public/programs/hh/facilities.aspx.	This requisition form can be taken to any licensed facil	ity providing healthcare services including hospitals and IHFs, such as those listed on t	