Alberta Health Services

Ultrasound Request

- Fax to Diagnostic Imaging; fax numbers listed at http://www.albertahealthservices.ca/diagnosticimaging
- *Urgent/Emergent requests must be discussed by direct consultation with the Imaging Specialist*

Preferred Facility

Patient label here or information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
Address (street, city, province, postal code)	
PHN	Daytime Phone
Inpatient location	WCB Claim Number

Referring Physician ***(PRINT** first and last name)*	Physician Phone *(required)*	Physician Fax *(required)*	Contact Number for Critical Test Results *(required)*

Signature	Date *(yyyy-Mon-dd)*	Copy to Physician *(first and last)*	Copy to Fax

Specific anatomical area to be examined

Relevant clinical history/presumptive diagnosis

Clinical question to be answered

Relevant Previous Imaging Studies

Location	Type	Date *(yyyy-Mon-dd)*	Attached copy
			☐ No ☐ Yes

Follow Up

Stat report requested
☐ No ☐ Yes *(phone/pager)*:

Patient follow up ☐ n/a
☐ In ER ☐ With GP ☐ Other *(specify)*:

Current Patient Condition

Condition	**No**	**Yes**	**If Yes:**
Patient Pregnant ☐ n/a	☐	☐	n/a
Contraceptive Use	☐	☐	n/a
Isolation Precautions	☐	☐	Specify:
Allergies	☐	☐	Specify:
Medications	☐	☐	
Mechanical lift/transfer required	☐	☐	Specify:
Research Study	☐	☐	Study Name: Study #:

Height ☐ cm ☐ in

Weight ☐ kg ☐ lbs

Obstetrical History *(if applicable)*

Describe

G	T
P	L
A	
LMP *(yyyy-Mon-dd)*	

Department Use Only Date format: *yyyy-Mon-dd* - Time format: *hh:mm*

Appointment Priority ☐ 24 hr ☐ 1 week ☐ Next Avail. ☐ Other *(specify)*:

Date Received	Time Received	Appointment Date	Appointment Time