Alberta Health Services

Ultrasound Request

- Facilities and phone numbers can be found at http://alberthealthservices.ca/facilities.asp
- Urgent/Emergent requests must be discussed by direct consultation with the radiologist

Patient label placed here *(if applicable)* or if labels are not used, minimum information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
PHN #	Phone #

Referring Physician *(Print first and last name)*	Physician Phone	Physician Fax
Physician Signature	Copy to Physician	Copy to Fax
Stat Report Requested ☐ Yes ▶ ☐ No	If Yes, Pager/Phone #	

Exam Requested

Specify Abdominal U/S	Isolation/Precautions ☐ Droplet ☐ Contact ☐ Airborne	Date Requested *(yyyy-Mon-dd)*

Specific anatomical area to be examined

Relevant Clinical History/Presumptive Diagnosis

Clinical question to be answered

Allergies

Medications	Interventional Cases *(yyyy-Mon-dd)* ☐ INR _____ ☐ PTT _____ ☐ PLTS _____

Obstetrical History *(if applicable)*

Describe	G_____ T_____ P_____ L_____ A _____ LMP *(yyyy-Mon-dd)*_____

Department Use Only

Exam Date *(yyyy-Mon-dd)*	Exam Time