Alberta Health Services

Ultrasound Request

- ALL fields must be completed in order to process request
- Fax to Diagnostic Imaging; fax numbers listed at *http://www.albertahealthservices.ca/diagnosticimaging*
- *Urgent/Emergent requests must be discussed by direct consultation with a radiologist*

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown		

Preferred Facility		Inpatient Location
Patient Phone Number *(Cell # preferred)*		Patient Address
City	Postal Code	WCB Claim Number
Ordering Provider Name	Provider ID	Department ID
Provider Fax	Provider Phone	Contact Number for Critical Test Results
Provider Address/Location	City	Postal Code

Locum ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____

Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last,first and middle)*	Copy to Fax

Requested Procedure

Reason for Exam

Clinical question to be answered

Relevant Previous Imaging Studies *(Mandatory)*

Modality	Location	Date *(dd-Mon-yyyy)*	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			***Weight*** ☐ kg ☐ lbs	***Height*** ☐ cm ☐ in
Condition	**No**	**Yes**	**If Yes:**	
Patient Pregnant ☐ n/a	☐	☐	Date of LMP:	
Contraceptive Use	☐	☐	Specify:	
Isolation Precautions	☐	☐	Specify:	
Allergies	☐	☐	Specify:	
Medications	☐	☐	Specify:	
Mechanical lift/ transfer required	☐	☐	Specify:	
Research Study	☐	☐	Study Name:	Study #:

Obstetrical History ***(if applicable)***

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

Department Use Only

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

Date Received *(dd-Mon-yyyy)*	Time Received *(hh:mm)*	Date of Appointment *(dd-Mon-yyyy)*	Time of Appointment *(hh:mm)*