Request for a **ULTRASOUND**

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MR | MRS. | MISS | MS

SURNAME: ________ **FIRST NAME:** ________ **MIDDLE INITIAL:** ________

ADDRESS: ________ **CITY:** ________ **PROVINCE:** ________

POSTAL CODE: ________ **PHONE** (work)**:** ________ **PHONE** (Home)**:** ________

DATE OF BIRTH: DD / MM / YY **AGE:** ________ **SEX:** ________

APPOINTMENT DATE: ________ **TIME:** ________

EXAMINATION REQUESTED:

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CLINICAL INFORMATION:

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PREGNANCY: ________ **LEAD USED:** ________	**RAD**	**TECH**

INCOMPLETE REQUESTS WILL BE RETURNED

________ M.D. ________ ________
SIGNATURE OF AUTHORIZING PHYSICIAN — PLEASE PRINT NAME — PRAC. NO.

PHONE NUMBER: ________ **ADDITIONAL COPY OF REPORT TO:** ________

FAX NUMBER: ________ **FAX NUMBER:** ________