Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Centre of Excellence in Obstetrical Ultrasound (CEOU) Requisition

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Clearly imprint patient identification card

Centre of Excellence in Obstetric Ultrasound
700 University Avenue, 3rd Floor, OPG Building
Toronto, Ontario, Canada M5G 1X6

- A complete and accurate referral MUST be faxed before an appointment will be made.
- **Doctor's offices are responsible for notifying the patient of their appointment time and date.**

Telephone 416-586-8556 Fax 416-586-8405

Patient Demographics

Patient name ______________________ Last ______________________ First

Date of birth ______________________ (YYYY MM DD) Health Card Number ______________ VC ______

Daytime telephone number (_____) ______________ Evening telephone number (_____) ______________

Address ____

Appointment Information

- **Please advise patients to arrive 15 minutes early.**
- **Patients arriving late may be re-scheduled.**

Preferred appointment information ☐ M ☐ T ☐ W ☐ T ☐ F ☐ A.M. ☐ P.M.

____

Appointment date ______________ (YYYY MM DD) Time ______________ (HH:MM)

Appointment Booking
For internal use only

______________ Scheduled Date

______________ Scheduled Time

______________ Scheduler's Initials

☐ **NT Scan (11^{+4} - 13^{+6} weeks)**

☐ EFTS (Enhanced First Term Screen) • **Blood requisition *MUST* be faxed with the NT requisition**

☐ NIPT (Non Invasive Prenatal Testing)

Ultrasound Information

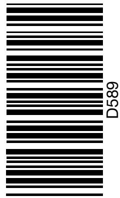
- **One CEOU Requisition is required for each test**

☐ Dating/Viability
☐ Complicated Anatomy (e.g., suspected anomaly/**early anatomy etc**)
☐ Routine/Level II Anatomy (19-20 weeks)
☐ Placental Study (22-24 weeks)
☐ BPP
☐ Transvaginal for ☐ Cervical length ☐ Placental location ☐ Scar thickness ☐ Other: ______________
☐ **+MFM Consult (Not offered on Wednesdays)**
☐ Other (specify) ______________________________

LMP ______________ (YYYY MM DD) ***OR*** Established EDC ______________ (YYYY MM DD)

Multiple Gestation? ☐ Yes ☐ No ☐ Unknown – If YES, specify number ______

External scan performed? ☐ Yes ☐ No – If YES, date of scan ______________ (YYYY MM DD) GA at time of scan ______________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Relevant Medical History

- **Please include copies of *external* ultrasound and prenatal screening reports.**

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Referring Healthcare Provider

______________________ Print Name ✘ ______________________ Signature

Telephone # (_____) ______________ Fax # (_____) ______________ Billing # ______________

Full mailing address ______________________ Additional copy to ______________________

______________________ ______________________