MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Centre of Excellence in Obstetric Ultrasound
700 University Avenue, 3rd Floor, OPG Building
Toronto, Ontario, Canada M5G 1X6
D 589 (Rev. 05.2012)

Centre of Excellence in Obstetrical Ultrasound (CEOU) Requisition

Clearly imprint patient identification card

- 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 (_____) _____

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**
(11-13^{+6} weeks)

- **For NT Ultrasound, please fax Requisition to: (contact information same as above)**
- **Blood requisition *MUST* be faxed with the NT requisition**

Ultrasound Information

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

☐ BPP
☐ BPP + MFM Consult
☐ Routine Anatomy (18-20 weeks)
☐ Complicated Anatomy (e.g., suspected anomaly)
☐ Dating/Viability
☐ Transvaginal (e.g., cervical length)
☐ Limited Scan (e.g., prior incomplete scan/visibility)
☐ 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 _____

Relevant Medical History

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

Referring Healthcare Provider

_____ (Print Name) ✘ _____ (Signature)

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

Full mailing address

_____

_____

_____

Additional copy to

_____

_____

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