PLEASE BRING THIS REQUISITION FORM TO YOUR APPOINTMENT:

DATE: ______________

TIME: ______________

514 QUEEN STREET

(TOP FLOOR)
SASKATOON, SK

PH: 306-933-4522
FAX: 306-933-0058

TO SCHEDULE AN EXAM:

306-933-4500

www.theultrasoundcentre.com

PATIENT NAME ______________________________

PHN ______________________________

D.O.B. ________ AGE ________ GENDER ________

PHONE ______________________________

ADDRESS ______________________________

REFERRING PHYSICIAN ______________________________

PHYSICIAN SIGNATURE ______________________________

PHONE ________ FAX ________

CC ______________________________

PHONE ________ FAX ________

EXAM REQUESTED/CLINICAL HISTORY:

***PLEASE INDICATE:** ☐ LEFT ☐ RIGHT ☐ BILATERAL

- ☐ SHOULDER
- ☐ BICEP
- ☐ ELBOW
- ☐ WRIST
- ☐ HAND
- ☐ HIP
- ☐ QUADRICEP
- ☐ HAMSTRING
- ☐ HERNIA
- ☐ KNEE
- ☐ CALF
- ☐ ANKLE
- ☐ FOOT
- ☐ ACHILLES
- ☐ OTHER: ______________

Thank you for your referral!

(Req up to date as of 2021)