SASK
SPORTS IMAGING
SASKATOON MEDICAL IMAGING // THE ULTRASOUND CENTRE

Please bring this requisition to your appointment.

DATE: _____

TIME: _____

514 Queen Street (Top Floor)
Unit 201 Saskatoon SK

www.theultrasoundcentre.com

Booking: 306-933-4500

Direct Phone: 306-933-4522
Direct Fax: 306-933-0058

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 RIGHT LEFT OR BILATERAL)

- ☐ SHOULDER
- ☐ BICEP
- ☐ ELBOW
- ☐ WRIST
- ☐ HAND
- ☐ HIP
- ☐ HAMSTRING
- ☐ KNEE
- ☐ CALF
- ☐ ANKLE
- ☐ FOOT
- ☐ OTHER

Thank you for your referral!