MAYFAIR® DIAGNOSTICS

REQUISITION

135, 1621 Albert Street
Regina, Saskatchewan S4P 2S5

ALL APPOINTMENTS:
Tel: 306.569.9729
Fax: 306.569.3337

PATIENT INFORMATION

PLACE PATIENT LABEL HERE

Date of Request: D/ M/ Y/

Name: ☐ Female ☐ Male

Address:

City: Province: Postal Code:

Home Phone: Other Phone:

Date of Birth: D/ M/ Y/

Saskatchewan Health Card Number:

WCB Number:

Appt. Date: D/ M/ Y/ Time: ☐ am ☐ pm

PROFESSIONAL SERVICE

*****Please see patient instruction on reverse*****

X-ray (No appointment necessary, walk-in basis)

☐ Examination:

Obstetrical Ultrasound

Check all current and future appointments needed.

1st Trimester

☐ Routine: (specify indication)

☐ Nuchal Translucency (GA 11w+0d – 13w+6d, preferably **after** 12 weeks)

☐ Other: (specify indication)

2nd Trimester

☐ Detailed exam >18 weeks

☐ Other: (specify indication)

3rd Trimester

☐ BPP: (specify indication)
- ☐ Doppler

☐ Fetal Growth: (specify indication)

☐ Other: (specify indication)

Vascular Ultrasound

☐ Venous (DVT) ☐ R ☐ L ☐ Arm ☐ Leg

General Ultrasound

☐ Complete Abdomen (Liver, Spleen, Pancreas, Kidney, Gallbladder, Aorta)
- ☐ Spectral Doppler

☐ RLQ/Appendix

☐ Renal (Kidneys, Bladder)

☐ Hernia

☐ IUCD Localization (Uterus only)
- ☐ Add Full Pelvic Assessment
- ☐ Add EV for 3D view of IUCD

☐ Pelvis (Bladder, Uterus, Ovaries, and Prostate for size)

☐ Thyroid

☐ Scrotum

☐ Mass:

☐ Other Exam:

Musculoskeletal Ultrasound

X-ray of the area may be required if recent trauma, or if no X-ray within last six months

☐ Shoulder (Includes Rotator Cuff)	☐ R	☐ L
☐ Elbow	☐ R	☐ L
☐ Wrist	☐ R	☐ L
☐ Carpal Tunnel	☐ R	☐ L
☐ Hand or Finger	☐ R	☐ L
☐ Hip	☐ R	☐ L
☐ Knee	☐ R	☐ L
☐ Bakers Cyst	☐ R	☐ L
☐ Ankle	☐ R	☐ L
☐ Achilles	☐ R	☐ L
☐ Foot or Toe	☐ R	☐ L
☐ Plantar Fascia	☐ R	☐ L

☐ Muscle/Tendon:

☐ Other:

HISTORY & PRESUMPTIVE DIAGNOSIS

Please complete this section with as many details as possible. This enables our clinic staff to provide the most comprehensive patient care.

☐ Stat Phone Report
Phone:

☐ Stat Fax Report
Fax:

REFERRER INFORMATION

*****All images and reports will be available on provincial PACS*****

Name:

Copy to:

Phone: Fax:

Address:

Practitioner's ID/Stamp:

☐ Send images with patient (CD copy)

Signature: