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

Affix Patient Label

PATIENT LABEL

Centre of Excellence in Obstetrical Ultrasound (CEOU) Requisition

700 University Avenue, 3rd Floor, OPG Building
Toronto, Ontario, Canada M5G 1X6 D 589 (Rev. 03.2022)

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

The following exams not performed at CEOU must be faxed to 416-586-3216

☐ MFM Consult ☐ TOP

Patient Demographics

Patient name _____ (Last) _____ (First)

Date of birth _____ (YYYY MM DD) Health Card Number _____ VC _____

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

Address _____

PATIENT CONSENT TO RECEIVE EMAIL COMMUNICATION: YES ☐ NO ☐

If yes, email address: _____ (***clearly print***)

Patient signature: _____

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)

Exam requested: One CEOU Requisition is required for each test

☐ **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)

☐ 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: _____

☐ 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 _____

D589

Relevant Medical History

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

Referring Healthcare Provider

☐ High Risk ☐ Low Risk

_____ (Print Name) ✘ _____ (Signature)

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

Date (of request) _____ (YYYY MM DD) CPSO # _____

Full mailing address _____

Additional copy to _____

- **Doctor's offices are responsible for notifying the patient of their appointment time and date.**