

Ultrasound/Fetal Monitoring Intake Form

Phone: 604-875-2900 Fax: 604-875-3013

PATIENT INFORMATION:

Date: _____

Referring MD/Midwife: _____ Billing# _____

Phone # _____ Private Line _____ Fax# _____

Copies to: _____ Billing # _____

Copies to: _____ Billing # _____

Yes No Is patient delivering at BC Women's Hospital?

OBSTETRICAL HISTORY:

G: ____ T: ____ P: ____ Ect: ____ SA: ____ TA: ____ L: ____

LNMP (d/m/y): _____ Singleton Multiples # _____ Unknown

Has patient had previous ultrasound exam(s)? No Yes (BCWH) Yes (Other facility) - ATTACH REPORTS

Does patient have upcoming ultrasound booked? No Yes Date: _____ Facility: _____

COPIES OF PREVIOUS ULTRASOUND REPORTS FROM OUTSIDE FACILITIES MUST BE INCLUDED WITH THIS FORM

EXAMINATION REQUESTED:

- Obstetrical Ultrasound
- Fetal Echocardiogram
- AFI/Doppler
- Nuchal Translucency (11⁰ - 13⁶ weeks)
- Non-Ob (In-Patient only - specify): _____
- Fetal Monitoring (NST)

INDICATIONS:

- Routine/Detailed (19-22 wks)
- Growth Assessment
- Post Dates Assessment
- Other: _____

Pertinent Information for Exam: _____

Priority: <48 hrs within 7 days Please book at: _____ weeks gestation

**** PLEASE NOTE: INCOMPLETE INTAKE FORMS WILL NOT BE PROCESSED ****

Referring office patient checklist:

- Yes No Ok for BC Women's Hospital to contact patient?
- Please ask patient to bring adult interpreter with them to their appointment if needed.
- Care Card and Photo ID
- Preparation instructions and full bladder
- Directions (Entrance #93)
- Web instructions and map
- Scent-free clinic
- Woman and provider aware of appointment date and time
- \$ Photo U/S

For BC Women's office use only:
 US/PN reports attached: _____
 Cerner scheduled: _____
 Triage by: _____
 GA: _____ EDD: _____ Initials: _____

PLEASE NOTIFY US IF UNABLE TO KEEP APPOINTMENTS SO THAT ALL POSSIBLE SPACE IS UTILIZED