ÉQUIPE DE SANTÉ FAMILIALE
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ByWard
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Ottawa, Ontario K1N 6N5

FAMILY HEALTH TEAM
www.bywardfht.ca
Fax/Téléc: 613-564-6627

ByWard Rheumatology - Musculoskeletal Ultrasound

Referring Physician Information

Name ______________________ Billing No. __________

Address ______________________ City __________ Province __________ Postal Code __________

Phone __________ Fax __________

Signature ______________________ Date __________

Patient Information

Name ______________________ Birth Date __________ (yyyy-mm-dd) Sex: ☐ M ☐ F

Prov. Health # __________ Expiry __________

Street Address ______________________ City __________ Province __________ Postal Code __________

Phone (Home) __________ Phone (Mobile) __________ Phone (Other) __________

Diagnosis

Medications

Exam Requested

☐ **Musculoskelatal Diagnostic Ultrasound**

☐ **U/S Guided Procedure >>** ☐ Aspiration ☐ Injection

Location

☐ **Shoulder**
- ☐ Left
- ☐ Right

☐ **Elbow**
- ☐ Left
- ☐ Right

☐ **Wrist/Hand**
- ☐ Left
- ☐ Right

☐ **Achilles Tendon**
- ☐ Left
- ☐ Right

☐ **Foot**
- ☐ Left
- ☐ Right

☐ **Plantar Fascia**
- ☐ Left
- ☐ Right

☐ **Knee**
- ☐ Left
- ☐ Right

☐ **Ankle**
- ☐ Left
- ☐ Right

☐ **Other**

Please specify: __________
- ☐ Left
- ☐ Right

Please complete and fax to: 613-564-6627