GBA Diagnostic Imaging Services

#10 Executive Office Centre, West Mall Drive, Freeport, Grand Bahama

Requisition Form

P.O Box: F43262 **Phone: 602-6655(Office), 818-2535(Cell)**

Email: gba.diagnosticimagingservices@gmail.com **Website: www.gbadiagnostic.com**

Date: ___________________

Last Name	*First Name*	*Initial*	*Date of Birth*	*Age*	*Sex*

Phone: _________________________

Email: ____

Clinical History/Indication:

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Ultrasound Study Requested: (Tick the box)

Abdominal – Complete		*Obstetrics (<14WOD) (transabdominal)*	
Abdominal – Limited		*Obstetrics (</=14WOD) (transabdominal)*	
Pelvic (transabdominal)		*Venous Doppler DVT (unilateral)*	
Pelvic (transvaginal)		*Venous Doppler DVT (bilateral)*	
Renal		*Venous Insufficiency (unilateral)*	
Renal Artery Doppler ultrasound		*Venous Insufficiency (bilateral)*	
Prostate		*Carotid Doppler (unilateral)*	
Scrotum / Testes		*Carotid Doppler (bilateral)*	
Soft Tissue Neck (thyroid, parathyroid, parotid)		*Doppler-Peripheral Arterial Disease (unilateral)*	
Soft Tissues (other)		*Doppler-Peripheral Arterial Disease (bilateral)*	
Breast – Unilateral		*Musculoskeletal (shoulder)*	
Breast – Bilateral		*Musculoskeletal (other)*	

Physician Name & Signature: ____
Contact: ____