



Diagnostic Imaging Department
INTERVENTIONAL RADIOLOGY

Mailing Address: OTMH 3001 Hospital Gate, Oakville, ON L6M 0L8
Phone: 905-338-4601 Fax: 905-845-9921

Incomplete / illegible requisitions will be returned resulting in delay to booking

PHYSICIAN INFORMATION:

Address: _____

Postal Code: _____

Phone: _____ Fax: _____

Copies to: _____

◆ Relevant clinical info; Discharge Diagnosis; Reason for study

Has Home Care been arranged? Yes No N/A

List any outside relevant studies. Reports of such MUST accompany this requisition – otherwise booking will be delayed:

Patient Past Medical History

- Yes No Allergies to contrast: _____
- Yes No Latex Allergy: _____
- Other allergies: _____
- Yes No Renal Disease
- Yes No Significant cardio-pulmonary disease
- Yes No History of diabetes
- Yes No History of excessive bleeding

Patient Medications

- Yes No Aspirin
- Yes No Metformin (Glucophage)
- Yes No Antibiotics: _____
- Yes No Anti-coagulants: _____
- Yes No Anti-platelet drug: _____
- Yes No Anti-inflammatory drug: _____

Yes No Does the patient require an interpreter?
NOTE: If the patient is unable to speak English, he/she must be accompanied by a translator or interpreter for the whole duration of the appointment

Yes No Is the patient able to sign consent?

Yes No Does the patient consent to HHS leaving information at home pertaining to his/her appointment?

If "YES", indicate phone number: _____

Physician Signature:

Please Print Name : _____

Name: _____ M / F

Address: _____

Phone (H) _____ (Cell) _____

(Work) _____

D.O.B. _____ Health Card #: _____

Unit #: _____

Procedure Requests (please check one)

Vascular

- Angiogram Venogram Angioplasty/Stenting
- Embolization – Site: _____
- Vena Cava Filter: Insertion Removal
- Other: _____

- Abscess Drainage
- Sinogram - Site: _____

- Paracentesis: Diagnostic Therapeutic
- Thoracentesis: Left Right AND Diagnostic Therapeutic

Please Specify Lab Tests Required for above (beyond Body Fluid Series):
_____ Cytology

Biopsy Site: _____

RFA Site: _____

Biliary

- Biliary Catheter (PTC): Insertion Change
- Cholecystostomy
- Cholangiogram

Venous Access: PICC (please specify below) Port Hickman

Single Double Triple Rationale: _____

Insertion Removal Exchange Evaluation

Urinary

- Nephrostogram: Left Right
- Nephrostomy: Insertion
- Change: Left Right
- Internalization

Gastrostomy: Insertion Change

Gastrojejunostomy: Insertion Change

Vertebroplasty

Joint Injection - Site: _____

Renal Program

IJ Tunneled Line

- New Line Line Removal
- Replacement Line: Line Infection Cuff Exposure
- Tunnel Infection Cracked Line
- Line Dysfunction

Fistulogram / Plasty

Fistulogram Only Fistulogram + Plasty De clot

Peritoneal Dialysis Line Consultation Only

New Insertion Consultation and Book

Removal

Manipulation – Reason: _____

APPOINTMENT DATE:

Day: _____ Month: _____ Year: _____

Time: _____

