Diagnostic Imaging

NUCLEAR MEDICINE
CONSULTATION REQUEST

Is the patient hearing impaired? ☐ **Yes** ☐ **No**

Appointment Date: _____ **Time**: _____

Guidelines:

1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. **Requisition is to be faxed to the Diagnostic Imaging Department at** 807-684-5907.
3. **All Regional referrals are to be faxed to the Regional Booking Office at** 807-684-5907.
4. Completed requisitions will be filed in the Booking Office.

Patient Name: _____ Date of Birth _____ /_____ /_____
day month year

Address: _____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____ Sex: ☐ Male ☐ Female

Health Insurance Card Number: _____ Version Code: _____

Workplace Safety and Insurance Board (WSIB) Claim Number: _____

Pregnant: ☐ Yes ☐ No Nursing ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No

If yes, specify: _____

_____

PRIORITY ASSESSMENT:

- ☐ **1 – Immediate** - Emergent
- ☐ **2 – Within 48 Hours** - Inpatient/Urgent
- ☐ **3 – Within 10 Days** - Semi-urgent
- ☐ **4 – Within 4 Weeks** - Non-urgent

CARDIOVASCULAR

CARDIOLITE:
- Treadmill ☐
- Persantine ☐
- dobutamine ☐

WALL MOTION (MUGA) ☐

GASTROINTESTINAL

GASTROINTESTINAL BLEED ☐

GALL BLADDER (BILIARY):
- with CCK (KINEVAC) ☐
- without CCK (KINEVAC) ☐

MECKEL'S SCAN ☐

LIVER/SPLEEN SCANS:
- red blood cell (RBC) liver (hemangioma) ☐
- sulfur colloid liver/spleen ☐

GASTRIC EMPTYING STUDY ☐

GENITOURINARY

RENOGRAM ☐

CAPTOPRIL ☐

DIURETIC ☐

GLUCO RENAL ☐

MUSCULOSKELETAL

BONE SCANS:
- whole body ☐
- specific site ☐

GALLIUM SCANS:
- whole body ☐
- specific site ☐

SENTINAL NODES

MELANOMA (with scan) ☐

BREAST STUDY (with scan) ☐

BREAST STUDY (without scan) ☐

LYMPHANGIOGRAM ☐

ENDOCRINE

THYROID UPTAKE ☐

THYROID SCAN ☐

PARATHYROID ☐

I131 WHOLE BODY SCAN ☐

I131 THERAPY ☐

dose: _____

NERVOUS SYSTEM

NEUROLITE (ECD) BRAIN SPECT ☐

RESPIRATORY

LUNG SCAN ☐

QUANTITATIVE LUNG ☐

HEMOPOIETIC

RED CELL MASS and PLASMA VOLUME ☐

OTHER TESTS:

PERTINENT CLINICAL INFORMATION:

TECHNOLOGIST USE ONLY:

Physician's Name (please print): _____

Physician's Signature: _____ **Date:** _____

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