Thunder Bay Regional Health Sciences Centre

PRIORITY OUTPATIENT DIAGNOSTIC REQUISITION FOR DISCHARGED PATIENTS

Place Patient Label with Barcode Here

Guidelines:

1. The requisition is completed by a Ward Clerk or Registered Nurse (RN) and signed by the RN or Referring Physician when booking outpatient diagnostic tests for patients who are being discharged.
2. Fax requisitions including Regional referrals to Diagnostic Imaging Central Intake **855-978-1862**. Please direct inquiries to Regional Bookings at 807-684-6681. After the requisition is faxed, file on the patient's health record. *PLEASE DO NOT SEND THE ORIGINAL TO DIAGNOSTIC IMAGING.* Incomplete requisitions will be returned resulting in delay of study.
3. The booking clerk will arrange appointment and contact patient.

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

Discharge Date: ________________ Appointment Date and Time: ____________________________

Patient Weight: ________________ Patient Contact Phone Number: __________________________

Tests Required	Indicate Body Part (please be specific)	Reason for Test
☐ CT (Computerized Tomography)	____________	____________
Is the patient diabetic? ☐ Yes ☐ No	List medications: ____________	____________
Recent Serum Creatinine (within one week)	____________	____________
☐ Radiology	____________	____________
☐ Ultrasound	____________	____________
☐ Echocardiogram	____________	____________
☐ EEG (Electroencephalogram)	____________	____________
☐ Nuclear Medicine	____________	____________
Scan Type ____________		Body Part ____________
☐ PFT (Pulmonary Function Test)	____________	____________
☐ Other ____________	____________	____________
☐ MRI (Magnetic Resonance Imaging)	____________	____________
Does the patient have any of the following?	Yes / No	____________
Pacemaker	☐ ☐	____________
Surgical Aneurysm Clips	☐ ☐	____________
Cochlear (Middle Ear) Implants	☐ ☐	____________
Prosthetic Heart Valve Replacement	☐ ☐	____________
Neuro Stimulator Device	☐ ☐	____________
Metal Fragments in Your Eye	☐ ☐	____________
Implanted Insulin/Chemotherapy Pump	☐ ☐	____________
Claustrophobia (no sedation provided)	☐ ☐	____________
Previous Spine Surgery	☐ ☐	____________

Any possibility of pregnancy? ☐ Yes ☐ No Date of Last Menstrual Period: ____________

Relevant Therapy/Medications: ____________

Allergies ☐ Yes ☐ No If yes, specify: ____________

Relevant Previous Studies:	When	Where	Radiologist Use Only
☐ MRI (Magnetic Resonance Imaging) Scan	________	________	Protocol: ________
☐ CT (Computerized Tomography) Scan	________	________	________
☐ Ultrasound	________	________	________
☐ Angiography	________	________	________
☐ X-Ray	________	________	________
☐ Nuclear Medicine	________	________	________

Referring Physician (please print) ____________________ **Date:** ____________

RN's Name (please print) ____________________ **RN's Signature and Designation:** ____________

Referring Physician's Signature: ____________________