Diagnostic Imaging

NUCLEAR MEDICINE
CONSULTATION REQUEST

Patient Name:____________________
D.O.B. (YYYY-MM-DD):____________________
Address:____________________
City/Town, Prov:____________________
Postal Code: __________ Tel: __________
Health Card #: __________ Version: ____
Place Patient Label with Barcode HerePlace

Regional Inpatient? **Yes** ☐ **No** ☐
Is the patient hearing impaired? **Yes** ☐ **No** ☐
Does patient require an interpreter? **Yes** ☐ **No** ☐

Appointment Date: ______________ **Time**: ________

Guidelines:
1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. Fax requisitions including Regional referrals to Diagnostic Imaging Central Intake **1-855-978-1862**.

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: ____________________
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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:** ______________