Thunder Bay Regional
Health Sciences
Centre

DIAGNOSTIC IMAGING
NUCLEAR MEDICINE

# SENTINEL INJECTION AND IMAGING

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**

**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**
3. Completed requisitions will be filed in Nuclear Medicine.

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: ________________________________________

**Operative Date and Time**

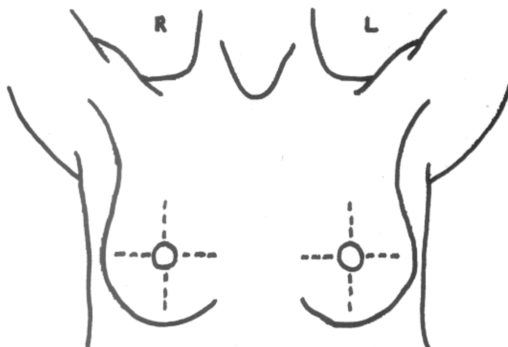
_________________________________

Breast ☐ Melanoma ☐

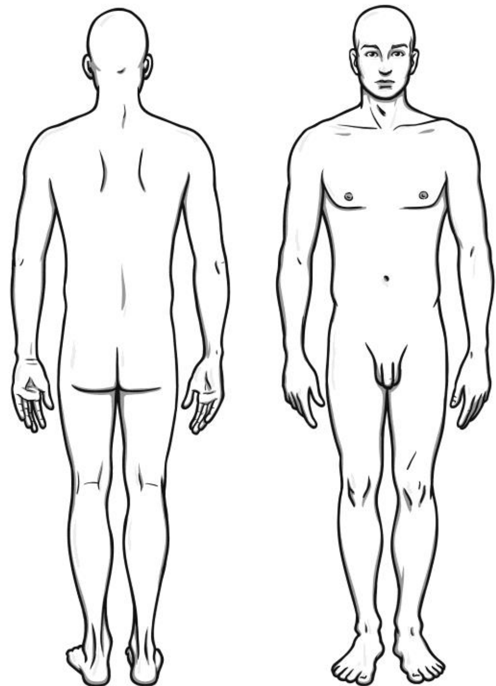
**Nuclear Medicine:**
**Appointment Date and Time**

_________________________________

**Patient is to report to:** **Nuclear Medicine:** ☐
**Surgical Day Care:** ☐




**Clinical Information**
**(please be specific and complete)**



**INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.**

Referring Physician (please print): ________________________________ Copy Report to: _____________
Physician's Signature: _________________________________________ Date: ______________________