Thunder Bay Regional Health Sciences Centre

DIAGNOSTIC IMAGING

INTERVENTIONAL 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 HerePlacePlace

Guidelines:

1. Physician to complete requisitions. 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. If any clarifications required, please contact Interventional Radiology Bookings office at 807-684-6559.
4. Requisition to be scanned into PACs. Completed requisitions will be filed in Interventional Radiology Bookings office.

Appointment Date & Time: _____ Is the patient hearing impaired? Yes ☐ No ☐

Does patient require an interpreter? Yes ☐ No ☐

A. PATIENT INFORMATION	
LAST NAME:	HC#: VC:
FIRST NAME:	WSIB CLAIM#:
ADDRESS:	SELF PAY:
	MALE ☐ FEMALE ☐
POSTAL CODE:	DATE OF BIRTH:
RESTRICTED MOBILITY, DESCRIBE NEEDS: ISOLATION PRECAUTION:	HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

B. EXAM INFORMATION *(MUST BE PROVIDED AND PLEASE BE SPECIFIC)*	
PROCEDURE REQUESTED:	FLUOROSCOPY GUIDANCE ☐ CT GUIDANCE ☐ US GUIDANCE ☐
RELEVANT CLINICAL INFORMATION:	

C. MEDICAL HISTORY			
CONTRAST ALLERGY:	YES ☐	NO ☐	*MEDICATION*
HYPERTENSION:	YES ☐	NO ☐	ANTIPLATELET (ASA/PLAVIX): YES ☐ NO ☐ TYPE:
RENAL DISEASE:	YES ☐	NO ☐	ORAL ANTICOAGULANT (WARFARIN): YES ☐ NO ☐ TYPE:
DIABETES:	YES ☐	NO ☐	OTHER:

D. BLOOD WORK	
DATE:	WHERE:
INR:	PTT:
PLATELETS:	CREATININE:

E. SIGNATURE	**F. RADIOLOGIST APPROVAL**
REFERRING PHYSICIAN NAME (***PRINT NAME CLEARLY & SIGN***) _____ *Print* _____ *Signature*	ROUTINE ☐ URGENT ☐ DI RECOVERY REQUIRED: YES ☐ NO ☐