niagarahealth
Extraordinary Caring. Every Person. Every Time.

INTERVENTIONAL RADIOLOGY REQUEST

☐ **OUT PATIENT Request**
(ONLY to SCS)
ST. CATHARINES SITE
FAX: 905-323-7560

☐ **IN PATIENT Request**
Enter O/E & FTP the Completed REQ
FTP Shortcut ID:
DI Interventional Procedure

☐ **OP PICC Line Request**

GNG	FAX: 905-358-7438
SCS	FAX: 905-323-7560
WHS	FAX: 905-732-9537

PHYSICIAN INFORMATION

Ordering Physician: ____________________

Please Print: ____________________

Signature: ____________________

Phone ____________ Fax ____________

Contact #: ____________ Copies to: ____________

Discussed with Radiologist:
☐ **Y** ☐ N Name of Radiologist: ____________

PATIENT INFORMATION

Last Name ____________ First Name ____________

Date of Birth (dd/mm/yyyy) ____________

Address ____________ City ____________

OHCN/OHIP# ____________ Version Code ____________

Phone: ____________ Mobile: ____________

Email: ____________

EXAM REQUESTED

All interventional radiology procedures including CT biopsy and US biopsy. (US breast, US thyroid and US small parts excluded) Please specify Lymphoma protocol, AFB, Fungal Culture.

____

____

CLINICAL INFORMATION / RELEVANT HISTORY: (include specific question to be answered)

____

____

Please answer the following:

1 Patient's Weight: ____________

#	Y	N	Question
2	☐ **Y**	☐ **N**	Known renal disease?
3	☐ **Y**	☐ **N**	Known diabetes?
4	☐ **Y**	☐ **N**	Known hypertension?
5	☐ **Y**	☐ **N**	Know contrast allergy?
6	☐ **Y**	☐ **N**	On Metformin?
7	☐ **Y**	☐ **N**	Can patient sign consent?
8	☐ **Y**	☐ **N**	Anticoagulant or antiplatelet?

↳ If yes, specify: ____________

Relevant tests already performed:

- ☐ CT
- ☐ Ultrasound
- ☐ X-Ray
- ☐ Angio
- ☐ Nuc Med
- ☐ MRI

Dates/Locations: ____________

DIAGNOSTIC IMAGING USE ONLY

Approved by Interventional Radiologist? ☐ **Y** ☐ **N** **Protocol #:** ____________

Please provide comments:

____

____

Priority: ☐ Routine ☐ Urgent Pre-medication required? ☐ Yes ☐ No Recovery bed required? ☐ Yes ☐ No

Modality ☐ US ☐ CT ☐ IVR ☐ Rm6 Performing DR: ☐ IR ☐ Other Radiologist ☐ GNG ☐ WHS

Tech Notes ☐ FTP to IVR - SCS ☐ IP Unit Notified

Tech name: ____________

Approved by: ☐ SA ☐ MA ☐ KT ☐ MC

Appointment: ____________
Date Time

To be completed by GNG/WHS Procedure Radiologist (if applicable)

Exam to be performed at ☐ SCS ☐ GNG ☐ WHS Radiologist: (Print Name) ____________

INCOMPLETE REQUISITIONS WILL BE RETURNED