

# 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:

Last Name

First Name

Please Print:

Date of Birth ( dd/mm/yyyy)

Signature:

Address

City

Phone

Fax

OHCN/OHIP#

Version Code

Contact #:

Copies to:

Phone:

Mobile:

Discussed with Radiologist:

Y  N

Name of Radiologist: \_\_\_\_\_

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: \_\_\_\_\_
- 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

Approved by:  SA  MA  ABR  MC

Tech name: \_\_\_\_\_

Appointment: \_\_\_\_\_

Date

Time

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

Exam to be performed at  SCS  GNG  WHS Radiologist: (Print Name) \_\_\_\_\_