niagarahealth
Extraordinary Caring. Every Person. Every Time.

INTERVENTIONAL RADIOLOGY REQUISITION

Depending on wait times, patients may be scheduled at any of our hospital sites in the Niagara region

PHONE: 905-378-4647
Ext: 46350 Fax: 905-323-7560

☐ OUTPATIENT
☐ INPATIENT
(ENTER O/E AND FTP THE COMPLETED REQ)
☐ OP PICC LINE

APPOINTMENT DATE/TIME/SITE: _____
DD / MM / YYYY HH : MM SITE

PATIENT INFORMATION (PLEASE PRINT)

PATIENTS LAST NAME		PATIENTS FIRST NAME	
ADDRESS		CITY	
MOBILE PHONE (PREFERRED CONTACT METHOD)	HOME PHONE	PROVINCE	POSTAL CODE
OHCN/OHIP#	VERSION CODE / PATIENT WEIGHT	DATE OF BIRTH (DD/MM/YYYY)	GENDER

ORDERING PROVIDER INFORMATION

ORDERING PROVIDER NAME **(PLEASE PRINT)**	COPIES TO
PHONE NUMBER	URGENT RESULTS CONTACT #
SIGNATURE	FAX NUMBER
DISCUSSED WITH RADIOLOGIST: ☐ YES ☐ NO	NAME OF RADIOLOGIST

EXAM REQUESTED:
ALL INTERVENTIONAL RADIOLOGY PROCEDURES INCLUDING CT BIOPSY, MSK ASPIRATIONS/INJECTIONS (SPECIFIC LAB ORDERS REQUIRED FOR ASPIRATIONS), US BIOPSY (US BREAST AND US THYROID EXCLUDED). PLEASE SPECIFY LYMPHOMA PROTOCOLS, AFB, FUNGAL CULTURE

CLINICAL INFORMATION / RELEVANT HISTORY:
(INCLUDE SPECIFIC QUESTIONS TO BE ANSWERED)

PLEASE ANSWER THE FOLLOWING:

KNOWN RENAL DISEASE? ☐ YES ☐ NO
KNOWN HYPERTENSION? ☐ YES ☐ NO
KNOWN DIABETES? ☐ YES ☐ NO
CAN PATIENT SIGN CONSENT? ☐ YES ☐ NO
KNOWN CONTRAST ALLERGY? ☐ YES ☐ NO ➔ **IF YES, PRE-MEDICATION PROVIDED?** ☐ YES ☐ NO
ANTICOAGULANT OR ANTIPLATELET? ☐ YES ☐ NO ➔ **IF YES, SPECIFY:** _____

RELEVANT TESTS ALREADY PERFORMED:

☐ CT ☐ ULTRASOUND ☐ XRAY ☐ ANGIO ☐ NUC MED ☐ MRI

DATE(S): _____ LOCATION(S): _____

OFFICE USE ONLY

APPROVED BY INTERVENTIONAL RADIOLOGIST? ☐ YES ☐ NO **APPROVED BY:** _____
PLEASE PROVIDE COMMENTS: _____
PRIORITY: ☐ ROUTINE ☐ URGENT **MODALITY:** ☐ US ☐ CT ☐ IVR ☐ IR2
PRE-MEDICATION REQUIRED? ☐ YES ☐ NO **PERFORMING DR:** ☐ IR ☐ OTHER RAD
RECOVER BED REQUIRED? ☐ YES ☐ NO **PROTOCOL #:** _____

TECH NOTES ☐ FTP TO IVR SCS ☐ IP UNIT NOTIFIED ☐ SENT TO MSK TECH NAME: _____

EXAM TO BE PERFORMED AT: ☐ SCS ☐ NFS ☐ WS ☐ MSK RADIOLOGIST: (PRINT NAME) _____

PLEASE NOTE: INCOMPLETE REQUISITIONS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT

Version 3: OCT2025