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 | |
| 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 AND US BIOPSY – US BREAST, US THYROID AND US SMALL PARTS 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 DIABETES?** ☐ YES ☐ NO

**KNOWN CONTRAST ALLERGY?** ☐ YES ☐ NO ➔ **IF YES, PRE-MEDICATION PROVIDED?** ☐ YES ☐ NO

**ANTICOAGULANT OR ANTIPLATELET?** ☐ YES ☐ NO ➔ **IF YES, SPECIFY:** _____

**KNOWN HYPERTENSION?** ☐ YES ☐ NO

**CAN PATIENT SIGN CONSENT?** ☐ YES ☐ NO

## 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 1: SEPT2025