

NUCLEAR MEDICINE REQUISITION



WOODSTOCK HOSPITAL

Department of Diagnostic Imaging
 310 Juliana Drive
 Woodstock, ON N4V0A4
 Phone: 519-421-4204 Fax: 519-421-4241
 Central Bookings
 Phone: 519-537-2381 Fax: 519-421-4238

Patient Information:

Name (Last, First): _____
 DOB: _____ M F PIN: _____
MMM DD YYYY
 Address: _____
 Phone Number (Home): _____
 (Other): _____
 Health Card Number: _____ Version Code: _____

Referring Physician or Other Authorized Health Care Provider

Name (Please Print): _____
 Phone: _____ Fax: _____

Ordering Physician or Authorized Health Care Provider Signature:

Copy to: _____
 Call Report to (Phone Number): _____

WSIB? (Please include approval for specific exam)
 Claim Number: _____ Date of injury: _____
 3rd Party or Insurance (Company or Self-pay): _____
 Patient Pregnant Patient Breast feeding
 Does this patient have special needs or impairments?
 (Please specify): _____

Clinical Indication, History: (reason for exam)

PATIENTS PRESENTING UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RE-BOOKED
 Please submit completed requisition and all supporting documentation by fax to Central Bookings: 519-421-4238

Examination(s) Requested:

Note: Nuclear Medicine scanner weight limit is 500 pounds

SKELETAL	LUNG	GALLIUM	ENDOCRINE
<input type="checkbox"/> Bone	<input type="checkbox"/> Ventilation Perfusion <input type="checkbox"/> Aspiration	<input type="checkbox"/> Lymphoma <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Sarcoid	<input type="checkbox"/> Parathyroid <input type="checkbox"/> Thyroid Scan <input type="checkbox"/> Uptake
BILIARY (HIDA)	CARDIAC	KIDNEY ❖	
<input type="checkbox"/> Cholecystitis <input type="checkbox"/> Post Cholecystectomy <input type="checkbox"/> Contractility (fat meal) <input type="checkbox"/> Biliary Leak	<input type="checkbox"/> Exercise (MIBI) <input type="checkbox"/> Persantine (MIBI) <input type="checkbox"/> Thallium Viability <input type="checkbox"/> Wall Motion (MUGA)	❖ Recent Serum Creatinine Required (collected within the last 60 days): _____ Date collected: _____ <input type="checkbox"/> Routine Renogram <input type="checkbox"/> Lasix <input type="checkbox"/> Captopril (for Hypertension)	
GI	SENTINEL NODE		OTHER
<input type="checkbox"/> GI Bleed <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Meckel's	<input type="checkbox"/> Liver or Spleen <input type="checkbox"/> Salivary <input type="checkbox"/> RBC Hemangioma Liver	<input type="checkbox"/> Breast <input type="checkbox"/> Melanoma (specify area): _____	<input type="checkbox"/> Dacryoscintigraphy (tear duct)

TECHNOLOGIST NOTES:

Appointment Date:

Appointment Time:

PLEASE BRING THIS REQUISITION AND YOUR HEALTH CARD
 Requirements and preparations for exams provided on page 2
 To cancel or reschedule your appointment please call Central Bookings: 519-537-2381



NUCLEAR MEDICINE PREPARATION AND INSTRUCTIONS

* For all appointments please notify technologist if you are pregnant or breast feeding *

Table with columns: EXAM, PREPARATION, DURATION. Rows include Bone, Cardiac MIBI, Cardiac Wall Motion, Gallium, Gastric Emptying, GI Bleed, Hepatobiliary (HIDA), Liver-Spleen, Lung Ventilation and Perfusion, Meckel's Scan, Dacroscentigraphy, Parathyroid, RBC Liver, Renogram Captopril (hypertension), Renogram Routine, Renogram Lasix, Salivary, Sentinel Node, Thyroid.

PLEASE CONTACT YOUR ATTENDING PHYSICIAN FOR ANY QUESTIONS REGARDING YOUR MEDICATIONS
To cancel or reschedule your appointment please call Central Bookings: 519-537-2381
For any questions regarding Nuclear Medicine please call: 519-421-4204

Please be aware that this is a "Fragrance Free" facility