MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

**Outpatient Diagnostic Imaging**
**REQUISITION FORM**

*Download link:* ***www.tehn.ca/imaging***

**Fax: 416-469-6662 Tel.: 416-469-6401**
Direct Nuclear Medicine Fax: 416-469-6853

**Clinical Information:**

*Please attach a Patient Sticker or fill in Patient Information below:*

Patient MRN (if known): _____

Patient Last Name: _____

Patient First Name: _____

Health Card #: _____ Version: _____

Address: _____

Postal Code: _____ D.O.B.: _____

Home Phone: _____

Cell Phone (optional): _____

Email (optional): _____

Patient would like to receive **Exam Reminders** via ☐ Text Messages or ☐ Emails

☐ WSIB or 3rd Party Case

## ☐ 1. CT ± Contrast (The questions below are mandatory)

Area to be scanned (please be specific):

**IV Contrast:** Please inform the patient that contrast may need to be injected

Known Contrast Allergy? ☐Y ☐N | Follow up exam? ☐Y ☐N

Premedication for Contrast Allergy (to be prescribed by Referring Physician): Prednisone , 50 mg PO - 13 hours and 1 hour pre-examination, plus Benadryl , 50 mg PO - 1 hour pre-examination

Patient pregnant? ☐Y ☐N . LMP, if yes: _____

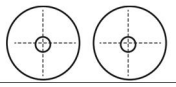
History of **Kidney Disease ( CKD, AKI, kidney surgery or ablation, albuminuria )**? ☐ Y ☐ N.
If Yes AND should the patient require a Contrast CT study, we will contact you to request eGFR *(test results must be within 90 days)*

Non-ambulatory patient? ☐Y ☐N | *Patient has to arrange for interpreter if he/she doesn't speak English*

**[DI Use Only]** IV Oral. Priority code: 1 2 3 4
Protocol:

## ☐ 2. DIGITAL MAMMOGRAPHY

☐ Routine ☐ OBSP
☐ Diagnostic ☐ Breast Biopsy
☐ Bilateral ☐ Right ☐ Left

R  L

Implants? ☐Y ☐N

## ☐ 3. VASCULAR DOPPLER LAB

| | | | |
|---|---|---|---|
| ☐ Arterial Upper Extremity | ☐R☐L | ☐ Renal Artery Scan | ☐R☐L |
| ☐ Arterial Lower Extremity | ☐R☐L | ☐ Venous Upper Extremity | ☐R☐L |
| ☐ Carotid | ☐R☐L | ☐ Venous Lower Extremity | ☐R☐L |

☐ Other VL exam:

## ☐ 4. X-RAY and FLUOROSCOPY (Please be specific)

| Requisition date | | Requested exam date | |
|---|---|---|---|

## ☐ 5. NUCLEAR MEDICINE

☐ Bone Scan Single Site ± Gallium
☐ Bone Scan Whole Body ± Gallium
Pregnant or lactating patient? ☐Y ☐N
Specific site: _____

Cardiolite Scan: ☐ Exercise ☐ Persantine
Consult with: ☐ 1st available ☐ Specific Cardiologist _____

☐ Renal Scan | ☐ Renal Scan with Lasix *(Urologists only)*

☐ Thyroid Uptake and Scan | ☐ Parathyroid | ☐ MUGA

☐ Other NM Exam:

## ☐ 6. ULTRASOUND

☐ Abdomen and Pelvis
☐ Abdomen ☐ Pelvis ☐ Kidney ± Bladder ☐ Liver

☐ Breast ☐ R ☐ L ☐ Breast Biopsy

☐ Face/Neck ☐ Thyroid ☐ Thyroid Biopsy

☐ MSK: _____ ☐ R ☐ L

OB: ☐ Dating (indicate LMP: _____)
☐ BPP

☐ Prostate ± Transrectal | ☐ Testes/Scrotum

Pediatric: ☐ Abdomen ☐ Brain ☐ Hips ☐ Spine

☐ Other U/S Exam:

## ☐ 7. BMD (Max. Patient Weight 350 Lb)

☐ Baseline | ☐ Follow up. Last BMD on: _____

☐ High Risk | ☐ The patient uses a wheelchair/walker

**Referring Physician** Name:

Fax:

Address and postal code:

Phone:

Signature:

*"I expect that the Radiologist will order additional exams on my behalf, related to the current investigation, if necessary."*

**[DI Use Only] Booking date:**

Email for non-confidential correspondence: **imaging@tehn.ca.**

*Form # SP933. Forms WG Approval Date: Feb 7, 2018. Rev. Nov 5, 2021*