

Medical Imaging Vascular and Interventional Radiology Consultation Request



Patient Label

Patient Last Name:		Given Name:		Date of Birth: (Day / Month / Year)	
Gender Identity:		Pronoun:		Accommodation required: ☐ No ☐ Yes: specify	
Address:		Apt#:		Telephone Number - Home: ()	
Town or City:		Province:		Postal Code:	
Contact Person / Caregiver / Guardian:		Relationship To Patient:		Telephone Number - Cellphone: ()	
Mobility Status: ☐ Walking ☐ Wheelchair ☐ Stretcher		Family Physician:		Telephone Number - Contact Person: ()	
☐ WSIB ☐ OHIP Health Card#:		Version Code		Email:	
☐ WSIB ☐ OHIP		Health Card#:		Hospital Patient ID No. / MRN:	
Billing: ☐ OHIP ☐ WSIB ☐ Non Resident / Other (insurance information must be attached)					

Required Questions:	WSIB	- Treatment due to a work related injury?	☐ No	☐ Yes
	INTERPRETER	- Language interpreter required?	☐ No	☐ Yes - If YES, language:
	PRIVACY	- American Sign Language interpreter required?	☐ No	☐ Yes
		- May we call the patient or leave a message? If NO, use Contact Person / Caregiver / Guardian	☐ No	☐ Yes
		- Able to provide consent:	☐ No	☐ Yes (if unable to provide consent, please attach details of power of attorney/ Substitute decision maker)

IMPORTANT PLEASE READ: INCOMPLETE OR ILLEGIBLE REQUESTS WILL NOT BE REVIEWED BY A RADIOLOGIST	Clinical History and Indication (be specific):	
	Procedure Requested:	
	☐ Biopsy	Cytology Required: ☐ Yes ☐ No Culture Required: ☐ Yes ☐ No
	☐ Angiography	☐ Interventional
	Imaging Work-up:	
	Has relevant imaging of the area been performed at Michael Garron Hospital: ☐ Yes ☐ No If not, outside images must be available <u>prior</u> to consultation. Please mail/deliver images and reports of those images to: Medical Imaging Reception Desk, Michael Garron Hospital labelled with patient name, date of birth and health card number.	
Blood Work: In order to ensure your patient's safety and procedural success MGH will contact you with respect to necessary preprocedural bloodwork and anticoagulation management (if any). Please ensure your patient is aware and compliant.		
Medical History:		
☐ History of Liver Disease ☐ Coagulation disorder ☐ Cardio-Pulmonary Disease ☐ Heparin Induced Thrombocytopenia ☐ Hypertension ☐ Other: Allergies: ☐ Yes ☐ No if yes, specify:		
Medication: (please attach list of ALL medications)		
☐ Aspirin ☐ Anticoagulants ☐ Anti-inflammatory drug ☐ Other:		

Referring Physician:	I, the undersigned regulated health professional, have discussed this referral with my patient and I request the radiologist reviewing to order any additional testing or imaging required (on my behalf) should the need arise.		
	Physician Name:		Telephone Number: ()
	Referring Clinic Name:		Fax Number: ()
	Physician's Signature:	Billing#:	Date: