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 (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: _____

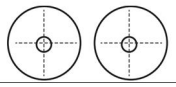
Is the patient **Diabetic**, **70+ years old**, or has **Renal Concerns**?
☐ Y ☐ N. If Yes, patient's Creatinine and weight are required:
Creatinine: _____ Date of test: _____
Weight: _____ ☐Kg ☐Lb *(must be within 90 days)*

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 (exams shown in alphabetical order)

☐ Abdomen and Pelvis
☐ Abdomen ☐ Pelvis
☐ Breast ☐R ☐ L ☐ Biopsy
☐ Face/Neck | ☐ Kidney ± Bladder
☐ MSK: _____
_____ ☐ ☐L
OB: ☐ Dating (indicate LMP: _____)
☐ U/S OB Routine (20 wks) ☐ BPP
Pediatric: ☐ Abdomen ☐ Brain ☐ Hips ☐ Spine
☐ Prostate±Tr/ Rect | ☐ Testes/Scrotum | ☐ Thyroid ☐ Biopsy
☐ 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.**

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