MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

OUTPATIENT DI 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)*

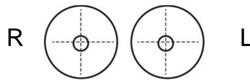
Non-ambulatory patient? ☐ Y ☐ N

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



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
Specific site: ____________________

Pregnant or lactating patient? ☐ Y ☐ N

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: ☐ Complete (with limited pelvic screen);
☐ Upper only (no pelvic screen)

☐ Breast ☐ R ☐ L ☐ Biopsy

☐ Face/Neck ☐ Kidney ± Bladder

☐ MSK: ____________________ ☐ R ☐ L

OB: ☐ Dating (indicate LMP: ______________)
☐ U/S OB Routine (20 wks) ☐ BPP

☐ Pelvis ± Transvaginal ☐ Prostate ± Transrectal

Pediatric: ☐ Abdomen ☐ Brain ☐ Hips ☐ Spine

☐ 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.**

Form # SP933. Forms WG Approval Date: Feb 7, 2018. Rev. 3/26/18