

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

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

Clinical Information:

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): _____

1. CT (The questions below are mandatory)

Area to be scanned (please be specific):

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

WSIB or 3rd Party Case

5. NUCLEAR MEDICINE

Bone Scan Single Site ± Gallium
 Bone Scan Whole Body ± Gallium
 Specific site: _____

Pregnant or lactating patient? Y N

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

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

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

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

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

Thyroid Uptake and Scan Parathyroid MUGA

Other NM Exam:

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

6. ULTRASOUND (exams shown in alphabetical order)

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*)

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

Breast R L Biopsy

Face/Neck Kidney ± Bladder

MSK: _____ R L

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

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

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

Pelvis ± Transvaginal Prostate ± Transrectal

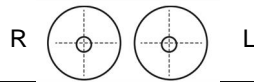
Pediatric: Abdomen Brain Hips Spine

Testes/Scrotum Thyroid Biopsy

Other U/S Exam:

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:

7. BMD (Max. Patient Weight 350 Lb)

Baseline Follow up. Last BMD on: _____
 High Risk The patient uses a wheelchair/walker

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

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: _____

Requisition date: _____ Requested exam date: _____