niagarahealth
Extraordinary Caring. Every Person. Every Time.

INTERVENTIONAL RADIOLOGY REQUEST

☐ **OUT PATIENT Request**
(ONLY to SCS)
ST. CATHARINES SITE
FAX: 905-323-7560

☐ **IN PATIENT Request**
Enter O/E & FTP the Completed REQ
FTP Shortcut ID:
DI Interventional Procedure

☐ **OP PICC Line Request**
GNG FAX: 905-358-7438
SCS FAX: 905-323-7560
WHS FAX: 905-732-9537

PHYSICIAN INFORMATION

Ordering Physician: Last Name First Name

Please Print: Date of Birth (dd/mm/yyyy)

Signature: Address City

Phone Fax OHCN/OHIP# Version Code

Contact #: Copies to: Phone: Mobile:

Discussed with Radiologist:
☐ **Y** ☐ N Name of Radiologist: Email:

EXAM REQUESTED

All interventional radiology procedures including CT biopsy and US biopsy. (US breast, US thyroid and US small parts excluded) Please specify Lymphoma protocol, AFB, Fungal Culture.

CLINICAL INFORMATION / RELEVANT HISTORY: (include specific question to be answered)

Please answer the following:

1 Patient's Weight: _____
2 ☐ **Y** ☐ **N** Known renal disease?
3 ☐ **Y** ☐ **N** Known diabetes?
4 ☐ **Y** ☐ **N** Known hypertension?
5 ☐ **Y** ☐ **N** Know contrast allergy?
6 ☐ **Y** ☐ **N** On Metformin?
7 ☐ **Y** ☐ **N** Can patient sign consent?
8 ☐ **Y** ☐ **N** Anticoagulant or antiplatelet?
If yes, specify:

Relevant tests already performed:
☐ CT
☐ Ultrasound
☐ X-Ray
☐ Angio
☐ Nuc Med
☐ MRI
Dates/Locations:

DIAGNOSTIC IMAGING USE ONLY

Approved by Interventional Radiologist? ☐ **Y** ☐ **N** **Protocol #:**
Please provide comments:

Priority: ☐ Routine ☐ Urgent Pre-medication required? ☐ Yes ☐ No Recovery bed required? ☐ Yes ☐ No
Modality ☐ US ☐ CT ☐ IVR ☐ Rm6 Performing DR: ☐ IR ☐ Other Radiologist ☐ GNG ☐ WHS

Tech Notes ☐ FTP to IVR - SCS ☐ IP Unit Notified
Tech name:

Approved by: ☐ SA ☐ MA ☐ ABR ☐ MC
Appointment:
Date Time

To be completed by GNG/WHS Procedure Radiologist (if applicable)
Exam to be performed at ☐ SCS ☐ GNG ☐ WHS Radiologist: (Print Name)

INCOMPLETE REQUISITIONS WILL BE RETURNED