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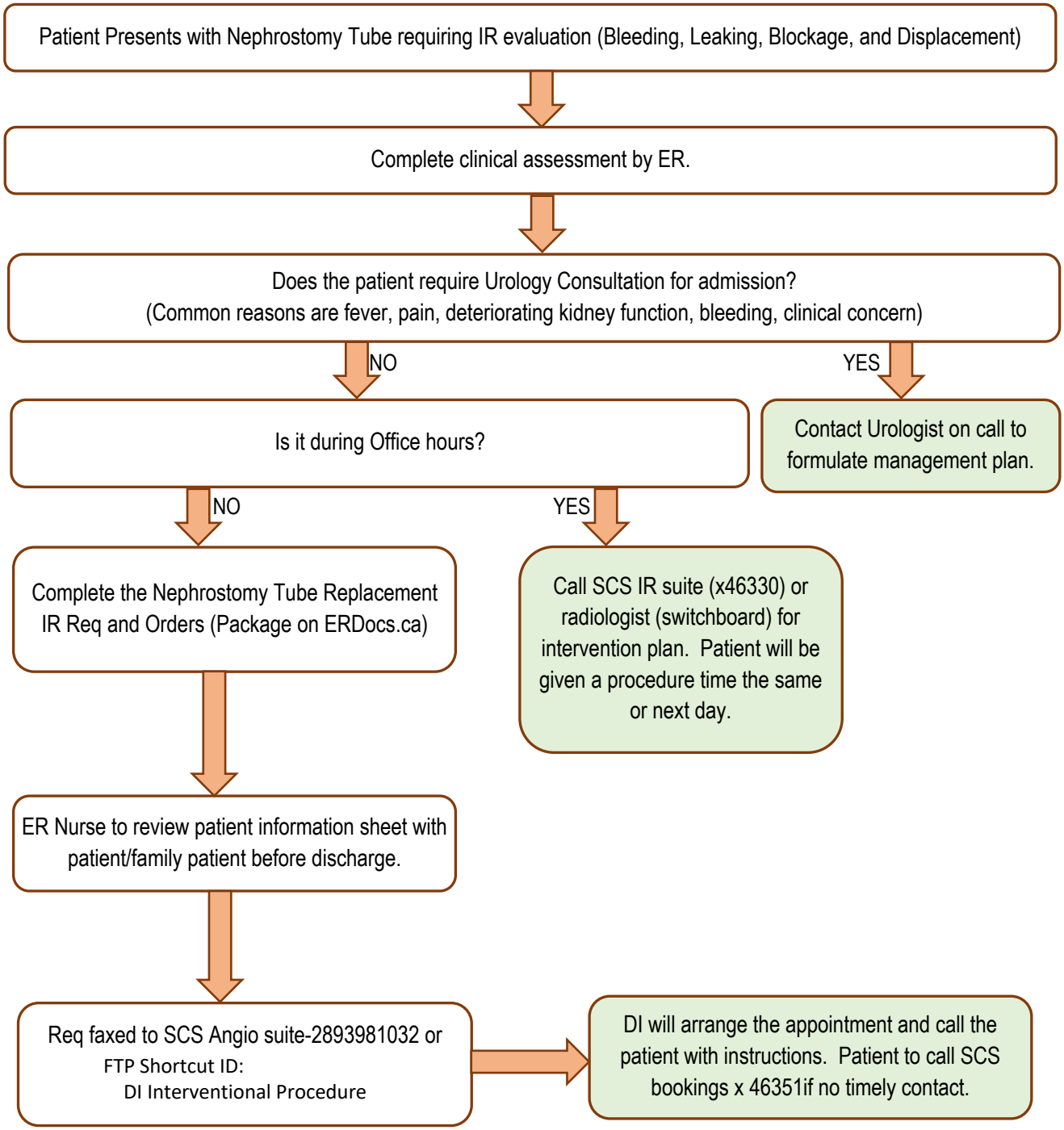
Nephrostomy Replacement ED Pathway



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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

Place Patient Sticker Here

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

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Nephrostomy Replacement ED/DI Patient Information Sheet

Appointment Date and Time _____
(if given by Interventional Radiologist)

The Emergency Department (ED) has referred you to have your nephrostomy tube evaluated and possibly replaced. Please make sure that you read this sheet carefully before leaving the ED and have all your questions answered by the staff.

This is an outpatient procedure that will be booked for you within 1-2 business days by the Diagnostic Imaging Department:

1. The procedure will be done at the Diagnostic Imaging Department at the St Catharines Site in the next 1-2 business days. It is located at 1200 Fourth Street Louth, St Catharines, ON.
2. You will need to arrive ½ hour before your scheduled appointment for your nephrostomy replacement to register at the main registration at the hospital for the procedure. There is no specific preparation required.
3. If not given an appointment before leaving the ED today, make sure you call in the morning of the first upcoming business day to get your appointment. Dial the hospital number 905-378-4647 then ext. 46351
4. The ED has no control over the appointment. It is booked directly by the Radiology bookings office. It is very important that you call and make sure you get your appointment ASAP. There is no follow up arranged through the ED after the procedure.
5. Please make sure your urologist's office is aware of the events should you require further care and follow up.
6. If your symptoms are worsening, especially if you have fever or severe pain, feeling unwell or excessive bleeding, please call 911 to return to the ED for reassessment.

After your nephrostomy tube evaluated or replacement, make sure you maintain your follow-up with your regular doctors (e.g. urologist or oncologist) for further care.

Your family doctor is the best way to access medical care and acts as the central person in your overall healthcare. If you do not have a family doctor, we strongly advise you to get one. You can find help at www.niagaradocs.ca or by calling Healthcare Connect Ontario at 1-800-445- 1822. The city of St Catharines provides similar information on their website www.stcatharines.ca or by calling 905.359.6043.

Thank You

PLEASE GIVE TO THE PATIENT PRIOR TO DISCHARGE FROM ED