

Referring Physician: (print first, last): \_\_\_\_\_  
 CPSO# \_\_\_\_\_ Signature: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Date: dd / mm / yy

## Interventional Radiology Requisition

Please fax to (905) 830-5966

**BY SIGNING THIS FORM, I CONFIRM PATIENT IS AWARE OF PROCEDURE & PROVIDED WITH ALL INSTRUCTIONS, INCLUDING MEDICATION TO PREPARE (SEE BELOW)**

Patient Name: (print first, last)		Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>
Address:	Street Number + Name	Apartment
	City	Province
		Postal Code
Health Card Number:	Version Code:	Patient Weight: _____ kg
Other Insurance:	Email:	Cell: ( )
Patient DOES NOT consent to be contacted via: <input type="checkbox"/> Text <input type="checkbox"/> Email (for patient privacy information see the next page)		
Patient not available: From: <u>dd</u> / <u>mm</u> / <u>yy</u> To: <u>dd</u> / <u>mm</u> / <u>yy</u>		
Hoyer Lift Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient arriving by Ambulance Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Relevant Clinical Information:</b> (must be provided and please be specific)		
Allergy to contrast? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Elevated Creatinine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please provide most recent result		
<b>Biopsy</b>	<b>Angiography/Angioplasty</b>	<b>Embolization</b>
<input type="checkbox"/> L Lung <input type="checkbox"/> R Lung <input type="checkbox"/> Liver <input type="checkbox"/> Renal <input type="checkbox"/> Lymph Node <input type="checkbox"/> Other (specify below)	<input type="checkbox"/> Angiography: (specify site) _____ <input type="checkbox"/> Angioplasty: (specify site) _____ PAD Category: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> U <input type="checkbox"/> X <i>*see page 3 PAD Category descriptions</i> <input type="checkbox"/> Venogram <input type="checkbox"/> Radiologist Consult +/- Angio/UFE	<input type="checkbox"/> Varicocele <input type="checkbox"/> Uterine Fibroid <input type="checkbox"/> Pseudoaneurysm Thrombin Injection <input type="checkbox"/> Other (specify below)
<b>Tube/Catheter</b>		
<b>1. Select Device</b>		<b>2. Select Procedure</b>
<input type="checkbox"/> Abscess (Drain) <input type="checkbox"/> Paracentesis (Drain) <input type="checkbox"/> G Tube or <input type="checkbox"/> GJ Tube <input type="checkbox"/> Biliary (Drain) <input type="checkbox"/> Port (Venous Catheter) <input type="checkbox"/> IVC Filter (Venous Intervention) <input type="checkbox"/> Cholecystostomy (Drain) <input type="checkbox"/> L <input type="checkbox"/> R Nephrostomy (Urinary Tract) <input type="checkbox"/> Pleural or <input type="checkbox"/> Peritoneal Tenckhoff <input type="checkbox"/> L <input type="checkbox"/> R Thoracentesis (Drain) <input type="checkbox"/> L <input type="checkbox"/> R Nephroureterostomy (Urinary Tract)		<input type="checkbox"/> Insertion <input type="checkbox"/> Removal <input type="checkbox"/> Check <input type="checkbox"/> Exchange
<b>Other Request (not listed above)</b>		
Specify:		
<i>Failure to provide the information requested below or notify patient of prep instructions may cause undue patient delays and/or this referral form being returned</i>		
<b>*PERI-PROCEDURE ANTICOAGULATION/ANTIPLATELET DISCONTINUATION:</b> <input type="checkbox"/> Not Applicable		
Referring physician is responsible for ensuring patient receives appropriate instructions on any necessary discontinuation of anticoagulation/antiplatelet pre-procedurally as per Diagnostic Imaging Guidelines on Discontinuation of Anticoagulants/Antiplatelet Associated Document on page 2 of this form. If it is deemed inappropriate or unsafe to discontinue anticoagulation/antiplatelet therapy, please consult Interventional Radiology at 905-895-4521 ext. 2384		
<b>Patient is on the following anticoagulant:</b> _____ and will hold _____ day(s) prior to procedure		
<b>Patient is on the following antiplatelet:</b> _____ and will hold _____ day(s) prior to procedure		
Does the patient require bridging? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include medication instructions and plan		
<input type="checkbox"/> NKA <input type="checkbox"/> ALLERGIES:		
<b>Required Attachments:</b>		
1. The patient may need to attend a pre-op clinic prior to their scheduled interventional procedure.		
2. Most recent blood work (done within 30 days) which must include CBC, INR, Creatinine/eGFR. Blood work available on: <input type="checkbox"/> Southlake Health <input type="checkbox"/> Connecting Ontario		
3. All relevant images and imaging reports: <b>Reports attached:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No relevant imaging		
<b>Images available on:</b> <input type="checkbox"/> Southlake Health <input type="checkbox"/> Other (image upload instructions required): _____		
<b>*An incomplete requisition will cause a delay in service to your patient, see preparation instructions on pages 2 and 3</b>		



**Diagnostic Imaging**
**Interventional Radiology Requisition**

### Diagnostic Imaging Guidelines on Anticoagulants/Antiplatelets Discontinuation

This document serves only as a guideline and does not replace individual clinician judgement. A cardiology consultation may be required in patients who have undergone PCI within 6 months or angioplasty within 2 weeks, or for patients on warfarin who may require bridging (e.g. mechanical valve, CHADS2 above 4, atrial fibrillation in the setting of mitral stenosis, VtE within 3 months or history of hypercoagulable state.)

**(Table 1) Assess the Risk of Bleeding Related to the Procedure**

Low Risk (Thresholds: INR ≤2.0, platelets ≥20,000)	High Risk (Thresholds: INR ≤1.5, platelets ≥50,000)
Catheter exchanges Chest tube placement Dialysis access interventions IVC filter removal IVC filter placement Joint and musculoskeletal injections Lumbar puncture Superficial biopsy/drainage (soft tissue, lymph node, breast, thyroid) Thoracentesis/Paracentesis Transjugular liver biopsy Tunneled drainage catheter placement Venography Venous catheter placement and removal (PICCs, ports, dialysis) Venous interventions	Arterial Interventions Biliary interventions Deep abscess drainage (lung, abdomen, pelvis) Deep biopsy Gastrostomy/gastrojejunostomy placement Solid organ biopsies Thrombolysis Urinary tract interventions

**(Table 2) Anticoagulants/Antiplatelets Discontinuation based on Bleeding Risk**

	Low Risk Bleeding Procedure	High Risk Bleeding Procedure
<b>Antiplatelets</b>		
<b>ASA (Aspirin®)</b>	Do not withhold	Hold 3 – 5 days
<b>Clopidogrel (Plavix®)</b>	Do not withhold	Hold 5 days
<b>Prasugrel (Effient®)</b>	Do not withhold	Hold 7 days
<b>Ticagrelor (Brilinta®)</b>	Do not withhold	Hold 5 days
<b>Oral Anticoagulants</b>		
<b>Apixaban (Eliquis®)</b>		
If CrCl 50 mL/min or above	Do not withhold	Hold 4 doses
If CrCl below 50 mL/min	Do not withhold	Hold 6 doses
<b>Dabigatran (Pradaxa®)</b>		
If CrCl 50 mL/min or above	Do not withhold	Hold 4 doses
If CrCl below 50 mL/min		Hold 6-8 doses
<b>Edoxaban (Lixiana®)</b>	Do not withhold	Hold 2 doses
<b>Rivaroxaban (Xarelto®)</b>		
If CrCl 30 mL/min or above	Do not withhold	Hold 2 doses
If CrCl below 30 mL/min		Hold 3 doses
<b>Warfarin (Coumadin)</b>	Hold 3 – 5 days	Hold 5 days
<b>Injectable Anticoagulants</b>		
<b>LMWH</b>	Do not withhold	Hold 1 dose if prophylactic, 2 doses if therapeutic
<b>Fondaparinux (Arixtra®)</b>		
If CrCl 50 mL/min or above	Do not withhold	Hold 2 – 3 days
If CrCl below 50 mL/min	Do not withhold	Hold 3 – 5 days
<b>Heparin</b>	Do not withhold	IV: Hold 4 hours, SC: wait 6 hours after last dose

**Diagnostic Imaging**

***Interventional Radiology Patient Preparation and Information***

**PATIENT PREPARATION:**

1. Please review ALL your medications with your physician or health care provider.
2. Blood thinning medications may need to be held prior to the procedure. Consult with your physician or health care provider. Guidelines for physicians on page 2.
3. Bring all your medications with you on the day of your pre-op visit and/or procedure.
4. Do not eat or drink for at least 4 hours prior to your procedure unless otherwise instructed.
  - Follow your physician’s instructions to hold blood thinning medications (if applicable).
  - If you take medications to control diabetes, do not take it within 4 hours of your procedure.
  - Take all other regular medications with sips of water.
5. Ensure to arrange for a responsible adult to drive them home following the procedure unless otherwise instructed.
6. Blood work done may be required prior to your scheduled appointment date. Your physician will provide a requisition if applicable.

**Incomplete preparation will usually require rescheduling of your procedure / treatment.**

**PAD Category**

Category	Description
<b>A</b>	<b>Asymptomatic peripheral artery disease — no prior intervention</b> Confirmation of atherosclerotic disease within the lower extremity/extremities with no limitation on physical activity and without prior revascularization or intervention.
<b>B</b>	<b>Intermittent claudication</b> Confirmation of atherosclerotic disease within the lower extremity/extremities accompanied by reproducible pain, cramping and/or fatigue specifically associated with exercise and/or physical activity that is relieved with periods of rest.
<b>C</b>	<b>Asymptomatic peripheral artery disease — primary assisted patency</b> Patient has undergone a previous revascularization, is asymptomatic and the prior revascularization site has experienced restenosis.
<b>D</b>	<b>Chronic limb-threatening ischemia/critical limb ischemia (CLTI/CLI)</b> Confirmation of atherosclerotic disease with ischemic rest pain and/or night pain within the lower extremity/extremities, with or without tissue loss and gangrene.
<b>E</b>	<b>Acute limb ischemia</b> Sudden onset of poor blood flow/ischemia to the lower extremity for less than 2 weeks typically due to embolism and thrombosis.
<b>U</b>	<b>Unknown</b> The stage of PAD is not documented.
<b>X</b>	<b>Not applicable</b> The intervention specified in the inclusion criteria was performed for non-PAD indications (e.g., trauma, iatrogenic injury)



**PRIVACY POLICY DOCUMENTATION**  
via QR code link below or via Southlake’s  
privacy office webpage