

Referring Physician: *(print first, last)*: _____
 CPSO# _____ Signature: _____
 Address: _____
 Office Phone: _____ Office Fax: _____
 Date: / /

Nuclear Medicine Requisition

Please fax to (905) 830-5966

Patient Name: <i>(print first, last)</i> _____		Date of Birth: <u> </u> / <u> </u> / <u> </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> </u> / <u> </u> / <u> </u> To: <u> </u> / <u> </u> / <u> </u> Reason: _____		
Hoyer Lift Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient arriving by Ambulance Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient pregnant or breastfeeding? <input type="checkbox"/> No <input type="checkbox"/> Yes		Venous access in situ: <input type="checkbox"/> Port <input type="checkbox"/> PICC
Clinical History and Diagnostic Question: _____		
EXAM REQUIRED <i>(check all that apply)</i>		
Endocrine <input type="checkbox"/> Parathyroid <input type="checkbox"/> Thyroid Uptake & Scan <input type="checkbox"/> Thyroid Scan Only <input type="checkbox"/> Thyroid Therapy <input type="checkbox"/> Whole Body Iodine Scan Neurological <input type="checkbox"/> Brain Perfusion <input type="checkbox"/> CSF Flow Scan <input type="checkbox"/> CSF Shunt Study Respiratory <input type="checkbox"/> Ventilation/Perfusion Lung <input type="checkbox"/> VQ with Quantification	Gastrointestinal <input type="checkbox"/> Liver/Spleen <input type="checkbox"/> R.B.C Liver <input type="checkbox"/> Hepatobiliary (HIDA) <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Salivary <input type="checkbox"/> GI Bleed <input type="checkbox"/> Meckel's Scan Skeletal <input type="checkbox"/> Bone Scan - Whole Body <input type="checkbox"/> Bone Local Site - (Specify/ laterality): _____	Genitourinary <input type="checkbox"/> Renal Scan (GFR) <input type="checkbox"/> Renal Scan (GFR) with Furosemide [Lasix] <input type="checkbox"/> Renal Captopril <input type="checkbox"/> Renal Cortical Scan Other Nuclear Medicine <input type="checkbox"/> Gallium Scan <i>(Specify):</i> _____ <input type="checkbox"/> Sentinel Node <i>(Specify/Laterality):</i> _____ <input type="checkbox"/> Other <i>(Specify):</i> _____
Cardiac	PATIENT PREPARATION / INFORMATION. Please read instructions carefully.	
<input type="checkbox"/> Amyloid Scan <input type="checkbox"/> Ventricular Function (MUGA) Rest	<ul style="list-style-type: none"> • No Preparation – estimated time 20 minutes (first visit), 1 hour (second visit) for imaging • No Preparation – estimated time of test is 1 ½ hours 	
Cardiac Perfusion (Myoview) <input type="checkbox"/> Exercise <input type="checkbox"/> Dipyridamole (Persantine) <i>Indicate reason</i> _____	<ul style="list-style-type: none"> • May have a light breakfast morning of your test (i.e. toast or cereal) • No caffeine/decaffeinated products/beverages for 24 hrs prior to test • Bring list of current medications • You may be at the hospital for 4 to 6 hours • Wear loose clothing and comfortable shoes. 	
*Referring Physician to advise regarding medication	→ 24 hours before appointment, stop:	<input type="checkbox"/> Medications with Caffeine
	→ 48 hours before appointment, stop:	<input type="checkbox"/> Beta Blockers <input type="checkbox"/> Dipyridamole/acetysalicylic acid (Aggrenox)
	→ 4 days before appointment, stop:	<input type="checkbox"/> Diltiazem/Verapamil <input type="checkbox"/> Sildenafil, Tadalafil (Viagra, Cialis, etc.) <input type="checkbox"/> Theophylline (Uniphyll, etc..)

PHYSICIANS: PATIENT PREP INSTRUCTIONS ARE ON THE REVERSE SIDE, PLEASE CHECK APPROPRIATE BOX INDICATING PATIENT INSTRUCTIONS GIVEN. EXAM CANCELLATIONS ARE REQUIRED 48 HOURS IN ADVANCE TO UTILIZE OUR RADIOISOTOPES EFFECTIVELY



Nuclear Medicine Patient Preparation and Information (please provide to patient)

PATIENT PREPARATION:		ESTIMATED TIME IN NUCLEAR MEDICINE
<input type="checkbox"/> BONE	<ul style="list-style-type: none"> No preparation 	20 minutes (<i>first visit</i>) - for injection, you may leave the department after. 1 hour (<i>second visit</i>) – Return 2 to 4 hours later for imaging
<input type="checkbox"/> BRAIN SPECT	<ul style="list-style-type: none"> No caffeine or alcohol for 24 hrs before scan Bring a list of your medications 	2 hours
<input type="checkbox"/> GALLIUM	<ul style="list-style-type: none"> No preparation 	15 minutes (<i>1st day</i>) – for injection 45 minutes (<i>2nd day</i>) – for imaging
<input type="checkbox"/> HIDA	<ul style="list-style-type: none"> Nothing to eat or drink after midnight 	1 to 3 hours
<input type="checkbox"/> GASTRIC EMPTYING TEST (GET)	<ul style="list-style-type: none"> Nothing to eat or drink after midnight Notify the department if you have an allergy to eggs (905-895-4521, ext. 2564) 	2 hours
<input type="checkbox"/> LIVER OR LUNG	<ul style="list-style-type: none"> No preparation 	1 hour
<input type="checkbox"/> MECKELS	<ul style="list-style-type: none"> Adults 18 years or older: obtain Famotidine (Pepsid, etc.) pills at your local pharmacy. Take 20mg of Famotidine 12 hrs prior to appointment time. Nothing to eat or drink after taking the Famotidine. Children under 18: will be premedicated via an IV solution in the department the morning of the test. Do not give the child any food or drink after midnight 	1 to 2 hours
<input type="checkbox"/> PARATHYROID SCAN	<ul style="list-style-type: none"> No preparation 	1 hour (<i>1st visit</i>) 2 appointment times ½ hour (<i>2nd visit</i>) 2 ½ to 3 hours apart
<input type="checkbox"/> RBC LIVER SCAN	<ul style="list-style-type: none"> No preparation 	1 hour (<i>1st visit</i>) 2 appointment times 40 minutes (<i>2nd visit</i>) 4 ½ to 6 hours apart
<input type="checkbox"/> RENAL SCAN	<ul style="list-style-type: none"> Drink 3 to 4 glasses of fluids prior to arrival May empty your bladder Bring a list of your medications Know your weight and height 	1 ½ hours
<input type="checkbox"/> SALIVARY	<ul style="list-style-type: none"> No preparation 	1 ½ hours
<input type="checkbox"/> THYROID UPTAKE WITH SCAN	<ul style="list-style-type: none"> Off thyroid medication for 2 weeks No IVP or CT contrast for 2 months Off kelp or vitamins with iodine for 2 weeks 	15 minutes (<i>1st visit</i>) - for pill 45 minutes (<i>2nd day</i>) – for imaging
<input type="checkbox"/> THYROID SCAN ONLY	<ul style="list-style-type: none"> Same preparation as Thyroid Uptake Scan 	45 minutes

PATIENT INFORMATION:

- Bring your Ontario Health Card.
- Bring the requisition. Diagnostic Imaging cannot perform any procedures without a requisition signed by a Physician or Nurse Practitioner.
- Upon arrival you are required to register for your appointment at one of our Welcome Centres before proceeding to Diagnostic Imaging Reception on East 2.
- If you are unable to keep your appointment, please call Patient Scheduling at 905-895-4521, ext 2665.



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