SouthlakeHealth

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Imaging

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Phone #: _____

Nuclear Medicine Cardiac Requisition

❑ IN-PATIENT ❑ OUT-PATIENT

Please fax to (905) 830-5966

Patient Name: *(print first, last)*		**Appointment Date:** dd / mm / yy
Address: Street Number + Name Apartment		**Appointment Time:**
City Province Postal Code		**Arrival Time:**
Health Card Number:	**Version Code:**	**Hospital Record #:**
Other Insurance:	**WSIB Number:**	**Date of Birth:** dd / mm / yy
Home: ( )	**Work/Other:** ( )	**Patient Weight:** _____ **kg**

Patient not available: From: dd / mm / yy To: dd / mm / yy **Reason:**

Is the patient Pregnant or Breastfeeding? ❑ No ❑ Yes **Venous Access in situ:** ❑ Port ❑ PICC

PHYSICIANS: TO SCHEDULE AN APPOINTMENT, FAX THE REQUISITION TO 905-830-5966.
EXAM CANCELLATIONS ARE REQUIRED 48 HOURS IN ADVANCE TO UTILIZE OUR RADIOISOTOPES EFFECTIVELY.

PROCEDURE	PATIENT PREPARATION / INFORMATION. Please read instructions carefully.
❑ **MUGA**	• No preparation - estimated time of test is 1 ½ hours
❑ **CARDIAC PERFUSION (Myoview)** *(Please indicate type)* ❑ Exercise ❑ dipyridamole (Persantine) *(Please indicate reason)* * *Referring Physician to advise regarding medication*	• May have a light breakfast morning of your test. *(i.e. toast or cereal)* • **No caffeine/decaffeinated products or beverages for 24 hours 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. → • **24 hours** before appointment, stop: ❑ Medications with caffeine → • **48 hours** before appointment, stop: ❑ dipyridamole/acetylsalicylic acid (Aggrenox) ❑ beta blockers ❑ Diltiazem/Verapamil → • **4 days** before appointment, stop: ❑ sildenafil, tadalafil (Viagra, Cialis, etc.) ❑ theophylline (Uniphyl, etc.)
❑ **CARDIAC VIABILITY (Thallium)** This is a two-day test *(referral from Specialists only)*	• May have a light breakfast each day. *(i.e. toast or cereal)* **1st day** – 2 appointments, ½ hour each; 3½ to 4 hours apart **2nd day** – 1 appointment, ½ hour

RELEVANT CLINICAL INFORMATION: *(must be provided and please be specific)*

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

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