WCHH WOMEN'S COLLEGE HOSPITAL Healthcare | REVOLUTIONIZED

Sinai Health System

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

NUCLEAR MEDICINE REQUISITION

76 Grenville Street, 2nd Floor, Toronto, ON M5S 1B2
Tel: 416-323-6400 ext.6184 Fax: 416-323-6311 http://www.womenscollegehospital.ca/programs-and-services/medical-imaging/

PATIENT IDENTIFICATION

PATIENT INFORMATION

Medical record number: _____ Health card number: _____ Version code: _____

Name: _____ _____ Date of Birth: _____/ _____/ _____ Sex: ❑ Female ❑ Male
First name Last name dd mm yyyy

Address: _____ City: _____ Province: _____ Postal code: _____

Home telephone: _____ Cell: _____ Business telephone: _____

Billing information: ❑ OHIP ❑ WSIB ❑ Non resident/Other Claim number/Insurance number:_____
(include attachments if necessary)

INDICATE THE TEST REQUESTED:

- ❑ Exercise Cardiolite Myocardial Perfusion Scan
- ❑ Persantine Cardiolite Myocariol Perfusion Scan
- ❑ Myocardial Viability Scan (Thallium-201)
- ❑ Whole Body Bone Scan
- ❑ Specific Site Bone Scan (specify site): _____
- ❑ Technetium-99m Thyroid Scan
- ❑ 2 & 24h Radioactive Iodine Uptake (RAIU)
- ❑ Iodine-123 Thyroid Scan
- ❑ Parathyroid Scan
- ❑ Salivary Gland Scan
- ❑ Iondine-131 MIBG Scan (Phaeochromocytom as)
- ❑ Lacrimal Duct Scan
- ❑ Biliary Scan
- ❑ Red Blood Cell Liver Scan (Hemangioma)
- ❑ Liver/Spleen Scan
- ❑ Esophageal Motility and Reflux Scan
- ❑ Carbon-14 Breath Test (H.Pylori)
- ❑ Gastric Emptying Scan (solid meat)
- ❑ Meckel's Diverticulum Scan
- ❑ Whole Body Gallium Scan (oncology)
- ❑ Labelled White Blood Scan (infection)
- ❑ Specific Site Gallium Scan (infection)
- ❑ Ventilation/Perfusion (V/Q) Lung Scan
- ❑ Renal Scan ____ Function with GFR ___ cortical
- ❑ Sentinel Node Scan (Breast) Left Right Bilateral
- ❑ Sentinel Node (Melanoma) (specify site): _____
- ❑ Other _____
- ❑ Iodine-131 Therapeutic Capsule (required Dose _____mCi)

SCREENING:

Pregnant or Breastfeeding? ❑ Yes ❑ No

Does the patient require an interpreter? ❑ Yes ❑ No

If yes, what language? _____

REFERRING HEALTHCARE PROVIDER INFORMATION (REQUIRED)

Referrer's Name:

_____ _____ _____
First name Last name Middle initial

Address: _____

City: _____ Postal code:_____

Telephone: _____

Fax: _____ CPSO number: _____

Signature: _____

Date: _____/ _____/ _____
DD MM YYYY

EXAM INFORMATION (REQUIRED)

Indication and Clinical History:

_____

_____

_____

_____

_____

_____

INCOMPLETE/ILLEGIBLE REQUESTS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT. FORM MUST BE COMPLETE, INCLUDING CLINICAL INFORMATION AND CLINICIAN SIGNATURE