Milton District Hospital
Oakville Trafalgar Memorial Hospital

Diagnostic Imaging Department

INTERVENTIONAL RADIOLOGY

Mailing Address: OTMH 3001 Hospital Gate, Oakville, ON L6M 0L8
Phone: 905-338-4601 Fax: 905-845-9921

Incomplete / illegible requisitions will be returned resulting in delay to booking

PHYSICIAN INFORMATION:

Address: ______________________

Postal Code: ______________________

Phone: ______________ Fax: ______________

Copies to: ______________________

♦ **Relevant clinical info; Discharge Diagnosis; Reason for study**

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Has Home Care been arranged? ❒ Yes ❒ No ❒ N/A

List any outside relevant studies. Reports of such MUST accompany this requisition – otherwise booking will be delayed:

____

Patient Past Medical History

❒ Yes ❒ No Allergies to contrast: ______________

❒ Yes ❒ No Latex Allergy:

❒ Other allergies: ______________

❒ Yes ❒ No Renal Disease

❒ Yes ❒ No Significant cardio-pulmonary disease

❒ Yes ❒ No History of diabetes

❒ Yes ❒ No History of excessive bleeding

Patient Medications

❒ Yes ❒ No Aspirin

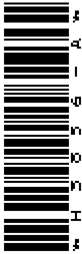
❒ Yes ❒ No Metformin (Glucophage)

❒ Yes ❒ No Antibiotics: ______________

❒ Yes ❒ No Anti-coagulants: ______________

❒ Yes ❒ No Anti-platelet drug: ______________

❒ Yes ❒ No Anti-inflammatory drug: ______________



❒ Yes ❒ No Does the patient require an interpreter?
NOTE: If the patient is unable to speak English, he/she must be accompanied by a translator or interpreter for the whole duration of the appointment

❒ Yes ❒ No Is the patient able to sign consent?

❒ Yes ❒ No Does the patient consent to HHS leaving information at home pertaining to his/her appointment?

If **"YES"**, indicate phone number: ______________

Physician Signature:

____

Please Print Name : ______________________

Name: ______________________ M / F

Address: ______________________

____

Phone (H) ______________ (Cell) ______________

(Work) ______________________

D.O.B. ______________ Health Card #: ______________

Unit # : ______________________

Procedure Requests (please check one)

Vascular

❒ Angiogram ❒ Venogram ❒ Angioplasty/Stenting

❒ Embolization – Site: ______________

❒ Vena Cava Filter: ❒ Insertion ❒ Removal

❒ Other: ______________

❒ Abscess Drainage

❒ Sinogram - Site: ______________

❒ Paracentesis: ❒ Diagnostic ❒ Therapeutic

❒ Thoracentesis: ❒ Left ❒ Right **AND** ❒ Diagnostic ❒ Therapeutic

Please Specify Lab Tests Required for above (beyond Body Fluid Series):

______________________ ❒ Cytology

Biopsy Site: ______________

RFA Site: ______________

Biliary

❒ Biliary Catheter (PTC): ❒ Insertion ❒ Change

❒ Cholecystostomy

❒ Cholangiogram

Venous Access: ❒ PICC(**please specify below**) ❒ Port ❒ Hickman

❒Single ❒Double ❒Triple Rationale: ______________

❒ Insertion ❒ Removal ❒ Exchange ❒ Evaluation

Urinary

❒ Nephrostogram: ❒ Left ❒ Right

❒ Nephrostomy: ❒ Insertion

❒ Change: ❒ Left ❒ Right

❒ Internalization

❒ Gastrostomy: ❒ Insertion ❒ Change

❒ Gastrojejunostomy: ❒ Insertion ❒ Change

❒ Vertebroplasty

❒ Joint Injection - Site: ______________

Renal Program

IJ Tunneled Line

❒ New Line ❒ Line Removal

❒ Replacement Line: ❒ Line Infection ❒ Cuff Exposure

❒ Tunnel Infection ❒ Cracked Line

❒ Line Dysfunction

Fistulogram / Plasty

❒ Fistulogram Only ❒ Fistulogram + Plasty ❒ Declot

Peritoneal Dialysis Line ❒ Consultation Only

❒ New Insertion ❒ Consultation and Book

❒ Removal

❒ Manipulation – Reason: ______________

APPOINTMENT DATE:

Day: ________ **Month:** ________ **Year:** ________

Time: ______________