PRHC Diagnostic Imaging Services

Angio Suite - Interventional Radiology Requisition - Outpatient

PATIENT LABEL

Fax: 705-876-5070

CONSULTATION FOR INTERVENTIONAL RADIOLOGY - OUTPATIENT
Isolation: ☐ No ☐ Yes **Type of Isolation:** ☐ Contact ☐ Droplet Contact ☐ Airborne

CLIENT/PATIENT INFORMATION		
Name:	DOB (DD/MM/YYYY):	☐ Male ☐ Female
Health Card #:	Phone #:	
Address:	City:	Postal Code:
☐ Inpatient ☐ Outpatient ☐ Wheelchair ☐ Ambulatory ☐ Non Ambulatory		
Hospital:	Transportation: ☐ Ambulance ☐ Car	

Requested Procedure:	Indication for Procedure:
For procedures requiring specimens, please list test required:	

INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED
Therefore delaying the booking process.

Physician Signature: _____

Printed Name: _____

Physician Contact #: _____

Report to: _____

Request Date (DD/MM/YYYY): _____

Additional Information requested by Interventional Radiologist

Current Bloodwork within 60 days of exam.

INR: _____

Platelets: _____

APTT: _____

HGB: _____

CREATININE: _____

Weight: _____

Creat. Clearance: _____

Date of Bloodwork (DD/MM/YYYY): _____

Is Patient Anticoagulated: ☐ No ☐ Yes

If YES, is patient taking: (check choice)

☐ ASA
☐ Plavix
☐ Coumaddin
☐ IV Heparin
☐ LMW Heparin
☐ Other (specify): _____

Please provide current medication list.

Is Patient Diabetic: ☐ No ☐ Yes
Insulin Dependent: ☐ No ☐ Yes
Metformin: ☐ No ☐ Yes

Previous Contrast Allergy: ☐ No ☐ Yes
If YES, explain:

Is Patient able to give informed Consent: ☐ No ☐ Yes
If NO, please have POA accompany patient