

# PRHC Diagnostic Imaging Services Nuclear Medicine Requisition

Fax: 705-743-1713 | Phone: 705-876-5039

PATIENT LABEL

CLIENT/PATIENT INFORMATION		
Name:	DOB (DD/MM/YYYY):	<input type="checkbox"/> Male <input type="checkbox"/> Female
Health Card #:	Phone #:	
Address:	City:	Postal Code:

PHYSICIAN INFORMATION		
Referring Physician:	Phone #:	Fax #:
Billing #:	Copies to:	

DIAGNOSTIC TEST REQUESTED	TEST DURATION
BONE <input type="checkbox"/> Whole Body Bone <input type="checkbox"/> Bone Specific Site	3.5 hours (2 appointments, 3hrs apart)
TUMOUR INFECTION <input type="checkbox"/> Gallium Whole Body <input type="checkbox"/> Gallium Specific Site (osteomyelitis)	Day 1: 15 min/ Day 3: 1.0 hr/ Day 4: 1.5 hrs Day 1: 15 min/ Day 3: 1.0 hr
ENDOCRINE <input type="checkbox"/> Thyroid Uptake and Scan <input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> <sup>131</sup> Iodine Therapy (Dose:	Day 1: 15 min/ Day 2: 1 hour 3.5 hours (2 appointments, 3hrs apart) 30 mins
RENAL <input type="checkbox"/> Renogram {GFR / Differential Function} <input type="checkbox"/> Lasix Renogram (Diuretic) <input type="checkbox"/> Captopril Renogram (Hypertension) <input type="checkbox"/> Renal Cortical Imaging (DMSA)	45 minutes 1.5 hours 1.5 hours 3.5 hours (2 appointments same day)
G.I. STUDIES <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Gastric Reflux and Aspiration (Paediatric Milk Study) <input type="checkbox"/> G.I. Bleed <input type="checkbox"/> Hepatobiliary (HIDA) <input type="checkbox"/> Liver/Spleen - R.B.C. (Haemangioma) <input type="checkbox"/> Liver/Spleen - Sulphur Colloid (SC) <input type="checkbox"/> Meckel's Diverticulum <input type="checkbox"/> Salivary - Parotid Scan	4 hours (4 appointments, 1 hr apart) 4 hours (4 appointments, 1 hr apart) 1.5 hour 1 to 3 hours 2 hours 1.0 hour 1.0 hour 1.0 hour
PULMONARY <input type="checkbox"/> Ventilation/Perfusion (Lung V/Q) <input type="checkbox"/> Quantitative Vent/Perf (Lung V/Q)	1.0 hour 1.0 hour
CARDIAC <input type="checkbox"/> MUGA (Myocardial Wall Motion with LVEF)	1.0 hour
NEUROLOGY <input type="checkbox"/> Brain Perfusion	1.5 hour
LYMPHATIC <input type="checkbox"/> Sentinel Lymph Node	1.5 hour
OTHER Nuc Med test	Please specify:

<p>CLINICAL INFORMATION:</p>  Physician's Signature: _____ Date (DD/MM/YYYY): _____	<p>LOCATION: Nuclear Medicine Department, Level 3 W3 Diagnostic Imaging</p> <p>Time: _____          Date (DD/MM/YYYY): _____</p> <p>BOOKING NOTES:</p>
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<p>TECHNOLOGIST COMMENTS:</p>	<p><b>PLEASE BRING THIS REQUISITION WITH YOU</b></p> <p>If you are pregnant or think you might be pregnant, please inform the Nuclear Medicine Technologist. If you are not able to attend this appointment, please call 705-876-5039 to cancel.</p>
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