PRHC Diagnostic Imaging Services

Requisition

Outpatient Booking: Fax: 705-743-7296 | Phone: 705-876-5039

PATIENT LABEL

Vascular Clinic – External Providers

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	
Is this WSIB? ☐ Yes ☐ No Claim #:		

PHYSICIAN INFORMATION		
Referring Physician:		
Phone #:	Fax #:	Billing #:
CC DR:	CC DR:	CC DR:

INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED

Arterial Extremities:	**Arterial Other:**	**Venous:**	**Reason For Exam:**
☐ ABI only (compression) ☐ Upper Extremity Arterial Doppler ☐ Lower Extremity Arterial Doppler (with ABI) ☐ First Assessment Fistula ☐ Fistula Surveillance RT / LT _____ _____ _____ _____	☐ Carotid/Vertebral ☐ Mesenteric Doppler ☐ Renal Artery ☐ AAA ☐ Screening ☐ Follow up (surveillance) _____ _____ _____ _____	☐ DVT - bilateral ☐ Unilateral RT / LT _____ _____ _____ _____	Relevant Risk Factors ☐ Previous Vascular Surgery ☐ Previous Bypass/Stent ☐ Claudication ☐ Rest Pain ☐ Tissue loss (ulcer) ☐ Smoker ☐ Diabetic ☐ Other Specify: _____ _____ _____ ☐ Request vascular consult + test ☐ Request ultrasound only

Priority:

☐ Urgent (24-48 Hours) ☐ Semi Urgent 3 - 7 days ☐ Elective ☐ Specific Date (DD/MM/YYYY): _____

Previous:

☐ At PRHC ☐ On Epic ☐ Outside (Previous Attached) ☐ New Consult ☐ No Relevant Previous

Prescriber Signature:	Date (DD/MM/YYYY):

One team, here when you need us most.

www.prhc.on.ca

PRHC
Peterborough Regional Health Centre