MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Outpatient Diagnostic Imaging
REQUISITION FORM

Download link: ***www.tehn.ca/imaging***

Fax: 416-469-6662 Tel.: 416-469-6401
Direct Nuclear Medicine Fax: 416-469-6853

Clinical Information:

Please attach a Patient Sticker or fill in Patient Information below:

Patient MRN (if known): _____
Patient Last Name: _____
Patient First Name: _____
Health Card #: _____ Version: _____
Address: _____
Postal Code: _____ D.O.B.: _____
Home Phone: _____
Cell Phone (optional): _____
Email (optional): _____

Patient would like to receive **Exam Reminders** via ☐ Text Messages or ☐ Emails

☐ WSIB or 3rd Party Case

☐ 1. CT (The questions below are mandatory)

Area to be scanned (please be specific):

☐ **IV Contrast.** Please inform the patient that contrast may need to be injected

Known Contrast Allergy? ☐Y ☐N | Follow up exam? ☐Y ☐N

Premedication for Contrast Allergy (to be prescribed by Referring Physician): Prednisone , 50 mg PO - 13 hours and 1 hour pre-examination, plus Benadryl , 50 mg PO - 1 hour pre-examination

Patient pregnant? ☐Y ☐N . LMP, if yes: _____

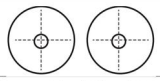
History of **Kidney Disease (CKD, AKI, kidney surgery or ablation, albuminuria)**? ☐ Y ☐ N.
If Yes, patient's eGFR is required: eGFR: _____
Date of test: _____ *(must be within 90 days)*
Note: **If eGFR is less than 60**, the referring physician decides on withholding Metformin

Non-ambulatory patient? ☐Y ☐N | *Patient has to arrange for interpreter if he/she doesn't speak English*

[DI Use Only] IV Oral. Priority code: 1 2 3 4
Protocol:

☐ 2. DIGITAL MAMMOGRAPHY

☐ Routine ☐ OBSP
☐ Diagnostic ☐ Breast Biopsy
☐ Bilateral ☐ Right ☐ Left

R  L

Implants? ☐Y ☐N

☐ 3. VASCULAR DOPPLER LAB

☐ Arterial Upper Extremity	☐R☐L	☐ Renal Artery Scan	☐R☐L
☐ Arterial Lower Extremity	☐R☐L	☐ Venous Upper Extremity	☐R☐L
☐ Carotid	☐R☐L	☐ Venous Lower Extremity	☐R☐L

☐ Other VL exam:

☐ 4. X-RAY and FLUOROSCOPY (Please be specific)

Requisition date		Requested exam date	

☐ 5. NUCLEAR MEDICINE

☐ Bone Scan Single Site ± Gallium
☐ Bone Scan Whole Body ± Gallium
Pregnant or lactating patient? ☐Y ☐N
Specific site: _____

Cardiolite Scan: ☐ Exercise ☐ Persantine
Consult with: ☐ 1st available ☐ Specific Cardiologist _____

☐ Renal Scan | ☐ Renal Scan with Lasix *(Urologists only)*
☐ Thyroid Uptake and Scan | ☐ Parathyroid | ☐ MUGA
☐ Other NM Exam:

☐ 6. ULTRASOUND

☐ Abdomen and Pelvis
☐ Abdomen ☐ Pelvis ☐ Kidney ± Bladder ☐ Liver

☐ Breast ☐R ☐L ☐ Breast Biopsy
☐ Face/Neck ☐ Thyroid ☐ Thyroid Biopsy
☐ MSK: _____ ☐R ☐L

OB: ☐ Dating (indicate LMP: _____)
☐ BPP

☐ Prostate ± Transrectal | ☐ Testes/Scrotum

Pediatric: ☐ Abdomen ☐ Brain ☐ Hips ☐ Spine

☐ Other U/S Exam:

☐ 7. BMD (Max. Patient Weight 350 Lb)

☐ Baseline | ☐ Follow up. Last BMD on: _____
☐ High Risk | ☐ The patient uses a wheelchair/walker

Referring Physician Name:
Fax:
Address and postal code:
Phone:
Signature:

"I expect that the Radiologist will order additional exams on my behalf, related to the current investigation, if necessary."

[DI Use Only] Booking date:

Email for non-confidential correspondence: **imaging@tehn.ca.**

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