Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

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**

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: _____