

Nuclear Medicine (NM) Requisition



HEALTH CARE

ST. PAUL'S HOSPITAL

Nuclear Medicine Department

1081 Burrard St., Vancouver, BC V6Z 1Y6

Appointments: 604-806-8008

Fax: 604-806-8075

MR MISS MRS MS		SURNAME		FIRST NAME		
PERMANENT ADDRESS						
POSTAL CODE		CELL PHONE	HOME PHONE		WORK PHONE	
DATE OF BIRTH (MONTH / DAY / YEAR)			AGE		SEX	
HEALTH CARE #			MSP	WCB	ICBC	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TO SCHEDULE AN APPOINTMENT PLEASE FAX OR MAIL COMPLETED REQUISITION TO NM DEPARTMENT. PATIENTS WHO DO NOT SPEAK ENGLISH MUST COME WITH AN INTERPRETER.

Appointment Date: _____ Time: _____

<p>Please Check Exam Requested</p> <p><input type="checkbox"/> Bone Scan <input type="checkbox"/> Extremity <input type="checkbox"/> Non Contrast CT <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Myocardial Perfusion Scan (MIBI) <i>Please complete Section A, B and C</i> <input type="checkbox"/> Proceed with Calcium Scoring if criteria met</p> <p><input type="checkbox"/> Renal Scan: Please complete section A <input type="checkbox"/> Captopril <input type="checkbox"/> Lasix</p> <p><input type="checkbox"/> Thyroid Uptake and Scan: <i>Please complete section A</i></p> <p><input type="checkbox"/> Sentinel Node Localization: <input type="checkbox"/> Breast <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Parathyroid Scan <input type="checkbox"/> With Non Contrast CT</p> <p><input type="checkbox"/> Labeled WBC Scan</p> <p><input type="checkbox"/> Other: _____</p>	<p>PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CLAUSTROPHOBIC? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, please provide sedation as needed.)</i></p> <p>ALLERGIES? <input type="checkbox"/> NKA or _____</p> <p>REASON FOR STUDY/HISTORY</p> <hr/> <p>SECTION A Medications: <input type="checkbox"/> Beta blockers <input type="checkbox"/> Propylthiouracil <input type="checkbox"/> Statins <input type="checkbox"/> Thyroid Hormone Replacement <input type="checkbox"/> ACE Inhibitors <input type="checkbox"/> Other: _____</p> <p>SECTION B Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previous MI (<i>Date and Location</i>): _____ <input type="checkbox"/> Previous Angiogram (<i>Date and Location</i>): _____ <input type="checkbox"/> Previous PCI/CABG (<i>Date and Location</i>): _____ <input type="checkbox"/> Internal Cardiac Defibrillator (<i>If YES, upper rate limit</i>): _____</p> <p>SECTION C Height: _____ cm _____ ins Weight: _____ kg _____ lbs</p>
---	---

Incomplete Requests will be Returned

M.D. _____ PRAC. NO. _____

SIGNATURE OF AUTHORIZING PHYSICIAN PLEASE PRINT NAME

PHONE RESULTS: NO YES PHONE NO: _____ ADDITIONAL COPY OF REPORT TO: _____