Reset

DIAGNOSTIC IMAGING – INTERVENTIONAL RADIOLOGY

IVR

QHC Quinte Health Care	MD Name:	Patient Name:
	Signature:	DOB:
	MD Phone:	HCN:
	Date: (d/m/y)	Home Phone:
FAX ALL REQUISITIONS TO: 613-969-5561	Copies to:	Cell Phone
	WSIB #:	Address:

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:

LOCATION: ☐ INPATIENT ☐ OUTPATIENT ☐ ED Patient In Hospital ☐ ED Patient Sent Home

PROCEDURE REQUESTED:

Patient Information	YES	NO
Breastfeeding	☐	☐
Pregnant or could be pregnant	☐	☐
Cardiac Pacemaker	☐	☐
Allergic to X-ray dye Specify reaction:	☐	☐
Other Allergies Specify:	☐	☐
On Anticoagulants or liver disorder/ Dysfunction? Specify:	☐	☐
On ASA/NSAIDS/anti-platelets	☐	☐

Special needs:

Patient's Current Weight:

LABORATORY DATA:

		Date of test:
INR		
Hb		
Plat		
APTT		
WBC:		

Competency:
If patient is not able to provide consent they must be accompaniend by their Substitute Decision Maker (SDM)

SDM Name:

SDM Contact Info:

	YES	NO
Home Care arranged for patients with drains, catheters, PICC, central lines	☐	☐
Joint steroid injection prescription provided to patient and filled	☐	☐

Urgency Score:

- ☐ Emergency
- ☐ 24-48 hours
- ☐ Within 5 days
- ☐ Routine

Direct consultation with IVR Radiologist (ext 2522) required for Emergent exams.

For Radiology Use Only:

Appt. Date & Time:

Date Booking Made:

Priority: 1 2 3 4 **Radiologist:**

PLEASE ENSURE REQUISITION IS COMPLETE . FAX REQUISITION TO 613-969-5561

Rev:2019