RESET

INTERVENTIONAL RADIOLOGY CONSULTATION

DIAGNOSTIC IMAGING DEPARTMENT TEL: 613 969 7400 X2860 FAX: 613 969 5561

PATIENT NAME:

Address with Postal Code:

Date of Birth:
Health card number:

Home Phone:
Work Phone:
Cell Phone:

Outpatient ☐ Inpatient ☐ Floor
Mode of Transport:
Walking ☐ Wheelchair ☐ Stretcher ☐

Procedure Requested:

Previous Relevant Imaging: US ☐ CT ☐ MRI ☐ Xray ☐
Date: Location:
If NO recent QHC imaging, send CD of external relevant imaging with requisition

Clinical History:

Patient Information	**Yes**	**No**
Breast Feeding	○	○
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:

Urgency Score:

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

If urgency score is 1 or 2 direct consultation with IR is required. After hours contact On-Call Radiologist

Physician Requesting Procedure: (PRINT)
****must be continuing care Physician****

Contact No. for Referring Physician:

Physician Signature:

Today's Date:

Laboratory Data: **Date of Test:**

INR	
Hb	
Plat	
APTT	
WBC	

NOTE: if abnormal, these Lab values need to be corrected by the ordering Physician

Competency:

If patient is incompetent they must be accompanied by SDM.
SDM Name:

SDM Contact Information:

Home Care Arranged:	**Yes**	**No**
For patients with drains, catheters, PICC or central lines	○	○
Joint Injections:		
Joint steroid injection prescription filled	○	○

For Radiology use only:

Appointment date and time:

Date booking made:

Priority Code: 1 2 3 4

Date of Request:

Radiologist:

PATIENT IDENTIFICATION

QUINTE HEALTHCARE CORPORATION

CONSENT TO TREATMENT

I hereby authorize _____and such physicians, surgeons, anaesthetists and other health practitioners whose assistance is required, to perform the following operation(s), test(s) and treatment(s):

_____

_____

_____

I acknowledge that _____ and I have discussed the nature of the operation(s), test(s) and treatment(s), the associated benefits and potential risks, in a manner that I understood. If any unexpected conditions are discovered during the above operation(s), test(s) and treatment(s), I consent to such operation(s), test(s) and treatment(s) which may be essential for the maintenance of life or vital function in addition to or in place of those authorized above.

_____ _____ _____

Signature of Patient **PRINT NAME** **Date YYY/MM/DD**

_____ _____

Signature of Substitute Decision Maker **PRINT NAME**

_____ _____

Date YYY/MM/DD **Relationship to Patient**

PATIENT IDENTIFICATION

QUINTE HEALTHCARE CORPORATION

CONSENT TO TREATMENT

TELEPHONE CONSENT

I confirm that I have explained by telephone, the nature of the treatment(s), the expected benefits, material risks, material side effects, alternative course of action and the likely consequences of not having the treatment(s) to: _____ and answered all questions.
Substitute Decision Maker.

Signature of Witness	PRINT NAME	Date YYYY/MM/DD

INTERPRETER DECLARATION

I believe I have accurately interpreted the conversation between _____
Physician/Health Care Practitioner

and _____ and I believe the person understood the information given.
Patient / Substitute Decision Maker

Signature of Interpreter	PRINT NAME
Mode of Communication	**Date YYYY/MM/DD**

EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) identified on this consent because the patient meets the Conditions for Emergency Treatment without Consent outlined in the Health Care Consent Act and the QHC Consent to Treatment policy #.

Signature of Physician/Health Care Practitioner	PRINT NAME	Date YYYY/MM/DD