FALSE CREEK HEALTHCARE CENTRE

Centric Health Surgical Centre

INTERVENTIONAL RADIOLOGY REQUISITION

Last Name	First Name		Middle Initial
Address	City	Province	Postal Code
Home Phone	Work Phone	PHN#	WCB/ICBC#
Date of Birth (DAY / MONTH / YEAR)	Gender ☐ F ☐ M	Weight Kg	Known Allergies

Priority: ☐ Routine ☐ Semi-Urgent ☐ STAT

SAFETY

Is the patient able to lie flat for 45 minutes?	YES	NO
Is the patient diabetic?	YES	NO
Is the patient pregnant or breast-feeding	YES	NO
Previous IV contrast reaction?	YES	NO
Is the patient able to give consent? (If the patient does not speak English they must be accompanied by an interpreter)	YES	NO
Is Kidney function abnormal?	YES	NO

If YES for the above **OR** if requesting a CT Abdomen/Pelvis **OR** Angiogram: a current (within 3 months) eGFR is **mandatory**.

eGFR: _____ Date: _____ INR: _____ Date: _____

Does the patient take anticoagulant/anti-platelet medication? YES NO

If **YES** please list medications:

*Patients may have to stop taking anticoagulant or anti-platelet medication prior to their appointment. If this is unsafe for your patient please consult a radiologist.

AREA/TYPE OF EXAMINATION

TYPE OF SCAN: ☐ ULTRASOUND ☐ FLOURO ☐ CT-SCAN ☐ RADIOLOGIST TO DECIDE

AREA TO BE EXAMINED:

HISTORY

History & Clinical Diagnosis: (Please include prior surgery, special instructions if any)	List Previous Relevant Exams/Studies: (Please submit images & reports).	Medication List:

PHYSICIAN INFORMATION

Referring Physician (please print): _____

Referring Physician Signature (required): _____ Date: _____

College License #: _____ Phone: _____ Fax: _____

Additional Copies: _____

OFFICE USE ONLY

Date of Exam: ____ / ____ / ____ Time: _____ Contrast: _____ mls. _____ Initials: _____

Protocol:

Contrast? YES NO

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