St. Michael's

Inspired Care. Inspiring Science.

Medical Imaging
30 Bond Street, Toronto, ON, M5B 1W8
3rd Floor, Cardinal Carter Wing
Website- http://bit.ly/2ucQCPA

Interventional Radiology Requisition

Fax: 416-864-5037
Phone: 416-864-5656

FOR MI OFFICE USE ONLY

Exam Date: _____

Arrival Time: _____

Exam Time: _____

A. PATIENT INFORMATION

MRN **DOB** *YYYY/MM/DD*

Last Name

First Name

Street Address

City **Postal Code**

Province **Country**

☐ **Interpreter: Language** _____

☐ **Restricted Mobility, please describe needs**

_____

☐ **Isolation** _____

Health Card #: **Version code:**

☐ **Self Pay** ☐ **IFH** ☐ **WSIB Claim #**: _____

☐ **Female**

☐ **Male**

☐ **Transgender - Female to Male**

☐ **Transgender - Male to Female**

☐ **Intersex**

☐ **Please Specify** _____

Patient Consents to leave message ☐ **Y** ☐ **N**

MOBILE: _____

HOME: _____

WORK: _____

B. EXAM INFORMATION

Date of request: *YYYY/MM/DD*

Exam requested:

Clinical information: (be specific)

C. MEDICAL HISTORY

History:

Contrast Allergy:	Y ☐	N ☐	CAD:	Y ☐	N ☐
Hypertension:	Y ☐	N ☐	Recent Stroke:	Y ☐	N ☐
Renal Disease:	Y ☐	N ☐	Recent VTE:	Y ☐	N ☐
Diabetes:	Y ☐	N ☐	Implanted Devices:	Y ☐	N ☐
AFIB:	Y ☐	N ☐			

Device type: _____

Date of insertion: _____

Medication:

Metformin:	Y ☐	N ☐
NSAIDS:	Y ☐	N ☐
Antiplatelet (ie. ASA/Plavix/Ticagrelor):	Y ☐	N ☐
Oral Anticoagulant (ie. Warfarin/NOAC/DOAC):	Y ☐	N ☐
Parenteral Anticoagulant (ie. LMWH):	Y ☐	N ☐

Other:

D. BLOOD WORK (Required ***before*** appointment is made) **(Results must be within 30 days)**

Date: _____

Creatinine: _____ INR: _____ Platelets: _____ PTT: _____

E. SIGNATURE

Doctor Name: _____

CPSO: _____ Billing #: _____

Fax #: _____

Phone #: _____

Referring Physician Signature _____ *Required*

F. RADIOLOGIST APPROVAL

Routine ☐ Urgent ☐ SDC ☐ OP ☐

Radiologist Signature _____ *Required*