

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

Diagnostic Imaging - FAX: 905-830-5966

## Interventional Radiology Requisition

 OUT-PATIENT     IN-PATIENT     ED PATIENT

<b>Patient Name:</b> <i>(print first, last)</i> _____		<b>Appointment Date:</b> <u>dd</u> / <u>mm</u> / <u>yy</u>
<b>Address:</b>	Street Number + Name _____	<b>Appointment Time:</b> _____
	Apartment _____	<b>Arrival Time:</b> _____
	City _____ Province _____ Postal Code _____	<b>Hospital Record #:</b> _____
<b>Health Card Number:</b> _____	<b>Version Code:</b> _____	<b>Hospital Record #:</b> _____
<b>Other Insurance:</b> _____	<b>WSIB Number:</b> _____	<b>Date of Birth:</b> <u>dd</u> / <u>mm</u> / <u>yy</u>
<b>Home:</b> (    ) _____	<b>Work/Other:</b> (    ) _____	<b>Patient Weight:</b> _____ kg
<b>Patient not available:</b> From: <u>dd</u> / <u>mm</u> / <u>yy</u> To: <u>dd</u> / <u>mm</u> / <u>yy</u> Reason: _____		

**PROCEDURE REQUEST:**
**RELEVANT CLINICAL INFORMATION:** *(must be provided and please be specific)*
**PAST MEDICAL HISTORY:**

 Diabetes:  Yes  No    Allergies:  Yes  No    If yes please specify: \_\_\_\_\_

**MEDICATIONS:**

Recommend Aspirin ®, Warfarin ®, or anti-platelet drugs be held for five (5) days prior to procedure.

Recommend Rivaroxaban (Xarelto ®) and Apixaban (Eliquis ®) be held for 48 hours prior to procedure.

Low molecular weight heparin should be held for 12 hours for all procedures except renal biopsy, new nephrostomy tube insertion and new biliary drainage tube insertion which require 24 hour hold.

Patients on Dabigatran (Pradaxa ®) should consult with their prescriber.

1. The patient may need to attend a pre-op clinic visit prior to their scheduled interventional procedure.  
**\*An incomplete requisition will cause a delay in service to your patient.**
2. Please attach most recent blood work, which must include the following: CBC, PTT, INR, Creatinine / eGFR.
3. Please provide patient with blood work requisition. This blood work must be completed within seven (7) days prior to their scheduled appointment date. Fax these results to the Diagnostic Imaging Department (905) 830-5966 prior to the procedure date.
4. Please attach all relevant imaging reports and/or outside imaging CDs.     No reports to attach     Reports attached

**BY SIGNING THIS REQUISITION, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS PROCEDURE.**

<b>Referring Physician:</b> <i>(print first, last)</i> _____	<b>CPSO #</b> _____	<b>Date:</b> <u>dd</u> / <u>mm</u> / <u>yy</u>
<b>Signature:</b> _____	<b>Office Phone:</b> (    ) _____	
<b>Address:</b> _____	<b>Fax Number:</b> (    ) _____	
<b>CLINIC USE ONLY</b>	<b>Date Received:</b> <u>dd</u> / <u>mm</u> / <u>yy</u>	



## ***Patient Preparation and Information***

### **PATIENT PREPARATION:**

1. All patients will have pre-procedural blood work done prior to procedure – obtain a requisition from your physician. Blood work should be done no more than 7 days prior to procedure.
2. Please review ALL of your medications with your physician or health care provider.
3. Blood thinning medications may need to be held prior to the procedure. Consult with your physician or health care provider.
4. Bring all your medications with you on the day of your pre-op visit and/or procedure.
5. Patients should not have anything to eat or drink for at least 4 hours prior to procedure unless otherwise instructed.  
\*\*\* Do not take diabetic medications. Take all other regular medications with sips of water. \*\*\*
6. All patients must have a responsible adult drive them home following the procedure unless otherwise instructed.

**Incomplete preparation will usually require rescheduling of your procedure / treatment.**

### **PATIENT INFORMATION:**

- **Bring your Ontario Health Card.**
- Upon arrival you are required to register for your appointment at one of our Welcome Centres or Self-Serve Kiosks before proceeding to Diagnostic Imaging Reception on East 2.
- If you are unable to keep your appointment, please call Patient Scheduling at 905-895-4521, ext. 2665.
- Depending on the type of procedure you are scheduled for, you may be required to be at the hospital for up to eight (8) hours. This time includes preparation time, procedure time, and recovery time.