



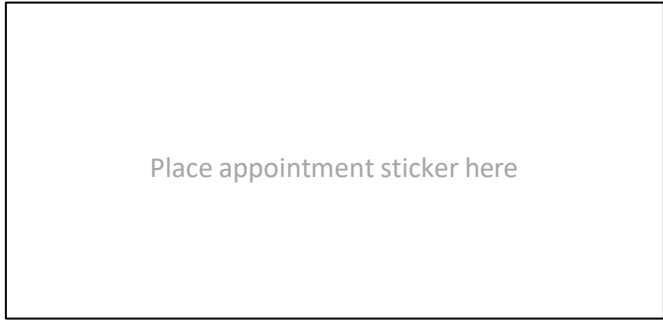
IMAGING REQUISITION
NUCLEAR MEDICINE/ BMD

Name: _____
ID Number: _____ DOB: _____
Pt. Phone Number: (____) _____ HC # _____

EXAM INFORMATION:

Location: Stratford Medical Imaging – W1-300 Nuclear Medicine
Register in the Medical Imaging Department - East Building
Phone: 519-272-8212
Fax: 519-272-8247

DEPARTMENT USE ONLY:



Is this Patient:

- An Inpatient
- In Isolation
- From a long term care Home (i.e. Nursing home)

Clinical Information (mandatory):

_____ PRIORITY DICTATION

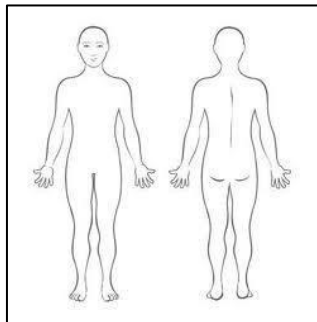
Physician Name (please print): _____ **Physician's Signature (mandatory)** _____ **Date** _____

Additional Copies to: _____

Nuclear Medicine (Stratford)

GENERAL:

- Bone Scan
- Lung V/Q
- Hepatobiliary (HIDA)
- Gastric Emptying
- Thyroid Uptake/Scan
- Thyroid Treatment
- Parathyroid Scan
- GI Bleed
- Meckel's Scan
- Gallium Scan
- RBC Liver Scan (hemangioma)
- Sulphur Colloid Liver/ Spleen Scan
- Spect CT- Parathyroid
- Melanoma Sentinel Lymph Node: site _____



(Indicate area of concern on diagram)

RENAL:

- Renal Function
- Lasix
- Captopril

CARDIAC:

- Stress Myocardial Perfusion
 - Treadmill
 - Pharmacologic
- Thallium (Viability)
- Wall Motion (MUGA)

Technologist Use Only:

* **Sentinel Lymph Node Localization (Breast lesion use BAC requisition)**

Bone Densitometry

- DEXA Bone Mineral Density (Clinton or Stratford) – (Please attach previous BMD reports)