IMAGING REQUISITION

NUCLEAR MEDICINE/ BMD

Name:____

ID Number: _______________ DOB: ____________________

Pt. Phone Number: (___)____________ HC #_______________

EXAM INFORMATION:

Location:	**Phone:**	**Fax:**
Stratford Medical Imaging – W1-300 Nuclear Medicine Register at Patient Registration West Building	519-272-8212	519-272-8247

DEPARTMENT USE ONLY:

Place appointment sticker here

Is this Patient:

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

____

Clinical Information (**mandatory**):

____

____

____ ☐ PRIORITY DICTATION

Physician Name (please print):_______________________ ______________________________ ____________________

Physician's Signature (mandatory) **Date**

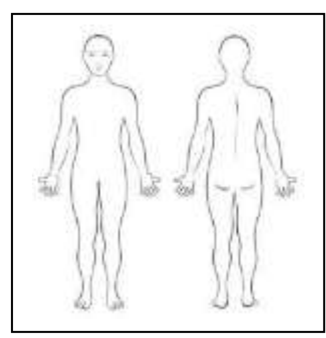
Additional Copies to:_________________________________

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
- ☐ DMSA Scan (scarring)

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)