IMAGING REQUISITION

IMAGE GUIDED BIOPSY OR DRAIN OUTPATIENT
(NOT FOR BREAST/THYROID/ PROSTATE)

Name:_____

ID Number: _____ DOB: _____

Pt. Phone Number: (___)_____ HC #_____

Clinical Information **(mandatory)**: _____

_____

_____ ☐ PRIORITY DICTATION

Physician Name (please print):_____ _____

Physician's Signature (mandatory)

Additional Copies: _____ _____

Date

Is this patient:
☐ An Inpatient
☐ In Isolation
☐ From a long term care home
(ie. Nursing home)
_____
_____

MANDATORY INFORMATION

Previous Imaging: ☐US ☐CT _____ @ SGH or _____

Procedure discussed with MI: Dr. _____or _____

Is this patient on Anticoagulants? ☐No ☐Yes Please specify drug, dose and reason for anticoagulation: _____

_____

Is it necessary to bridge the anticoagulation? ☐ No ☐ Yes What physician will manage this? _____

Other health issues of concern: ☐ Cardiac ☐ Renal ☐ Respiratory ☐ O2 dependent ☐ Mobility ☐ Hoyer lift _____

Can the patient consent for the procedure? ☐Yes ☐ No --If not, who is the Power of Attorney? _____

(Full name and contact #)

APPOINTMENT INFORMATION

Date: _____**Time:** _____ a.m. p.m.

☐ Your patient has been notified of this appointment.

☐ Please notify your patient of appointment. Note required prep and registration location.

- ☐ **Register in Medical Imaging 1st floor East Building North**
- ☐ **Register in Surgical Services 2nd floor East Building North**
- ☐ **Please notify the POA that they must be present at time of Procedure**

PREP INFORMATION:

- ☐ No prep required
- ☐ Nothing to eat or drink past midnight
- ☐ Please come with a driver
- ☐ See attached Prep sheet

IMAGING DEPARTMENT USE ONLY:

MI Clerical to enter: ☐US ☐CT of _____ ☐US ☐CT ☐Guidance ☐Biopsy of liver

☐ ABSCESS DRAINAGE

Request approved by Radiologist: _____ Date _____

Stratford Medical Imaging Ph 519-272-8212 Fax 519-272-8247 Procedural Nurse Ph 519-272-8210 Ext 2346