Orillia Soldiers' Memorial Hospital
170 Colborne St. West, Orillia, ON L3V 2Z3 Tel: **705-327-9127** Fax: **705-330-3224**

Request for Interventional Procedure

(By Appointment Only)

PATIENT INFORMATION	MRN No.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**

Last Name		**First Name**		
Date of Birth (d/m/y)	☐ M ☐ F	**Health Card No.**	**WSIB No.**	**3rd Party Ins. No.**
Address				
City	**Postal Code**	**Contact Number**	☐ **OK to leave voice mail message**	

PROCEDURE REQUESTED:

RELEVANT CLINICAL HISTORY:

IF URGENT, PLEASE CONTACT RADIOLOGIST

RELEVANT IMAGING / REPORTS ☐ OSMH ☐ OTHER ➔ Specify Location: _____

PATIENT ANTICOAGULATED ☐ NO ☐ YES ➔ Specify Medication: _____

ALLERGY TO CONTRAST MEDIA ☐ NO ☐ YES ➔ Specify Allergy: _____

RENAL DYSFUNCTION ☐ NO ☐ YES

DIABETIC ON METFORMIN ☐ NO ☐ YES

RADIOLOGIST USE

BOOKING PRIORITY ☐ **1** ☐ **2** ☐ **3** ☐ **4**

DAY SURGERY ☐ **YES** ☐ **NO**

CONSCIOUS SEDATION ☐ **YES** ☐ **NO**

LABS NEEDED ☐ **INR** ☐ **PTT** ☐ **CBC** ☐ **Creatinine**

FOR DEPARTMENT USE ONLY

PRIORITY: ☐ P1 ☐ P2 ☐ P3 ☐ P4

MODALITY _____

Radiologist Signature: _____

ADDITIONAL INSTRUCTIONS:

PHYSICIAN INFORMATION

Physician's Name (Please PRINT clearly)		OFFICE STAMP:
Address/ Phone	**CPSO#**	
Physician's Signature X		

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.