



REQUEST FOR Nuclear Medicine Examination

Tel: 705-327-9127 Fax: 705-330-3224

• BY APPOINTMENT ONLY •

PATIENT INFORMATION		MRN N ^o	APPOINTMENT DATE:		TIME:
<input type="checkbox"/> IN-PATIENT <input type="checkbox"/> OUT-PATIENT <input type="checkbox"/> ER		ARRIVAL TIME:			
Last Name			First Name		<input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth (D/M/Y)	Health Card N ^o	WSIB N ^o	3rd Party Ins. N ^o		
Address					
City	Postal Code	Contact Number	<input type="checkbox"/> OK to leave voice mail message		
Patient is able to give consent for this procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No			Does the patient have a glucose monitoring device? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.					
<input type="checkbox"/> SDM Name:		<input type="checkbox"/> SDM Contact Information:			

Patient requires assistance to complete this imaging exam, e.g. mobility, translation **Please Specify:**

General Nuclear Medicine

- | | | |
|--|---|---|
| <input type="checkbox"/> BONE SCAN | <input type="checkbox"/> RENAL SCAN (Perfusion) | <input type="checkbox"/> SENTINEL NODE (Breast) |
| <input type="checkbox"/> Site: _____ | <input type="checkbox"/> RENAL SCAN (Lasix) | <input type="checkbox"/> SENTINEL NODE (Melanoma) |
| <input checked="" type="checkbox"/> Whole Body | <input type="checkbox"/> RENAL SCAN (Captopril) | Melanoma Site: _____ |
| <input checked="" type="checkbox"/> SPECT | <i>Patients should be well hydrated prior to their renal scan. Imaging is 1 – 2h.</i> | |
| <input type="checkbox"/> SPECT/CT | <i>No special patient preparation. Imaging for melanoma patients may take up to 2h.</i> | |

Bone scans do not require any special preparation. Patients are injected and return 2 – 4 hours later for imaging. Imaging is 45m – 1h.

Other Nuclear Medicine Procedure (please specify): _____

Nuclear Cardiology

- | | |
|--|---|
| <input type="checkbox"/> MYOCARDIAL PERFUSION IMAGING (CARDIOLITE) | <input type="checkbox"/> MUGA SCAN |
| <input type="checkbox"/> TREADMILL | <i>No patient preparation required.</i> |
| <input type="checkbox"/> PERSANTINE | |

*Cardiolite tests performed on two separate days.
Day 1 patient preparation includes: no caffeine 24 hours prior to the test, no fatty/oily foods the morning of the test, and hold medications unless specified otherwise by a physician.
Day 2 preparation is identical except that patients may take their medications as normal. A letter containing further instructions will be mailed to the patient at the time of appointment booking.*

Physician's Name (Please PRINT clearly)		Physician's Signature
Phone	CPSO#	
INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.		