Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

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

REQUEST FOR

Interventional Procedure

• BY APPOINTMENT ONLY •

PATIENT INFORMATION	MRN N⁰.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**
Last Name	First Name		☐ M ☐ F
Date of Birth (D/M/Y)	Health Card N⁰.	WSIB N⁰.	3rd Party Ins. N⁰.
Address	City		Postal Code
Email Address	Contact Number		**OK to leave voice mail message**

Patient is able to give consent for this procedure: ☐ Yes ☐ No

Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ **SDM Name:** ☐ **SDM Contact Information:**

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

RELEVANT IMAGING / REPORTS ☐ OSMH ☐ OTHER ➔ Specify Location or supply:

PROCEDURE REQUESTED:	**RELEVANT CLINICAL HISTORY:**
	Note: ALL biopsies require recent bloodwork. See coagulation section.

IF URGENT, PLEASE CONTACT RADIOLOGIST

COAGULATION

☐ INR (MM / DD / YYYY): _____

☐ PTT (MM / DD / YYYY): _____

☐ PLATELETS (MM / DD / YYYY): _____

Referring physician must supply most recent bloodwork (≤ 4 weeks) and ensure patient receives appropriate instructions on any necessary discontinuation of anticoagulation/antiplatelet medications pre-procedurally. If it is deemed inappropriate or unsafe to discontinue anticoagulation/antiplatelet therapy, please consult Interventional Radiology at: 705-327-9127.

☐ I HAVE ORDERED THE FOLLOWING ON THIS DATE (MM / DD / YYYY): _____

☐ INR/PT ☐ PTT ☐ Platelets ☐ CBC ☐ HGB ☐ WBC ☐ Creatinine

☐ OTHER _____

PATIENT ANTICOAGULATED ☐ NO ☐ YES ➔ Specify medication and dose: _____

Patient is on the following anticoagulant: _____ and will hold ____ day(s) prior to procedure

Patient is on the following antiplatelet: _____ and will hold ____ day(s) prior to procedure

HEMATOLOGY	**RENAL FUNCTION (within 3 months)**	**ALLERGIES**	
☐ HGB: MM / DD / YYYY RESULT	☐ Creatinine: MM / DD / YYYY RESULT	Previous reaction to IV contrast: ☐ NO ☐ YES	
☐ WBC: MM / DD / YYYY RESULT	☐ eGFR: MM / DD / YYYY RESULT	*If **YES**, patient may require pre-medication prior to procedure.*	
Patient Diabetic: ☐ **NO** ☐ **YES**	Renal Insufficiency: ☐ NO ☐ YES	Other Allergies:	Weight: _____
Taking Metformin: ☐ NO ☐ YES	On Dialysis: ☐ NO ☐ YES		Height: _____
Insulin Dependent: ☐ NO ☐ YES	If **YES**, Dialysis Schedule: ☐ **M** ☐ **T** ☐ **W** ☐ **T** ☐ **F** ☐ **S** ☐ **S**		

Note: The following **REQUIRE bloodwork PRIOR** to the procedure: **Vascular access** (angio, PICCs, ports, dialysis lines, embolizations), **Core Biopsies** (lung, liver, kidney, or abdominal/pelvic), **Percutaneous drain and catheter insertions**, and **vascular line/device removals**.

Physician's Name (Please PRINT clearly)	
Phone	**CPSO#**

Physician's Signature

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