Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

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

REQUEST FOR

Nuclear Medicine Examination

• BY APPOINTMENT ONLY •

PATIENT INFORMATION	MRN N°.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**
Last Name		First Name	☐ M ☐ F
Date of Birth (D/M/Y)	Health Card N°.	WSIB N°.	3rd Party Ins. N°.
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:**

General Nuclear Medicine

☐ BONE SCAN
- ☐ Site: _____
- ☑ Whole Body
- ☑ SPECT
- ☐ SPECT/CT

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

☐ RENAL SCAN (Perfusion)
☐ RENAL SCAN (Lasix)
☐ RENAL SCAN (Captopril)

Patients should be well hydrated prior to their renal scan. Imaging is 1 – 2h.

☐ SENTINEL NODE (Breast)
☐ SENTINEL NODE (Melanoma)
Melanoma Site: _____

No special patient preparation. Imaging for melanoma patients may take up to 2h.

☐ Other Nuclear Medicine Procedure (please specify): _____

Nuclear Cardiology

☐ MYOCARDIAL PERFUSION IMAGING (CARDIOLITE)
- ☐ TREADMILL
- ☐ PERSANTINE

☐ MUGA SCAN

No patient preparation required.

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)

Phone | **CPSO#**

Physician's Signature

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

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