Soldiers' MEMORIAL HOSPITAL Orillia

REQUEST FOR

Interventional Procedure

• BY APPOINTMENT ONLY •

Tel: **705-327-9127** Out-Patient Fax: **705-330-3224** In-Patient Fax: **705-325-0582**

PATIENT INFORMATION

MRN N⁰. | Isolation Status

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ED ☐ AHF

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:

CLINICAL QUESTION AND RELEVANT CLINICAL INFORMATION
(Must be provided and must be specific)

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): _____

Low Bleed Risk Procedure*: Bloodwork not required unless on Warfarin **(INR ≤ 2.5; <2 for ports/tunneled lines)** or bleeding risk history **(CBC, INR, PTT; platelets ≥ 20).**

High Bleed Risk Procedure*: CBC (platelets ≥ 50) **+ INR** (≤ 1.8) within 2 weeks (72 hrs if inpatient) **+ PTT** are all required.

Ensure patient receives anticoagulant/antiplatelet instructions.
If unable to discontinue, consult IR: 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**		

Please see OSMH website, Diagnostic Imaging, for a complete list of low- and high-bleeding risk procedures.

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

Address | **Fax #**

Physician's Signature

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