Soldiers' MEMORIAL HOSPITAL Orillia

REQUEST FOR

Nuclear Medicine Examination

• BY APPOINTMENT ONLY •

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

PATIENT INFORMATION | MRN N°. | Isolation Status

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ED ☐ AHF

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

☐ Specific Site (SPECT/CT)

☐ 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.

☐ PARATHYROID SCAN

☐ MECKEL'S DIVERTICULUM SCAN

☐ BILIARY SCAN (HIDA)

☐ SALIVARY SCAN

☐ SENTINEL NODE (Breast)

☐ SENTINEL NODE (Melanoma)

Melanoma Site:

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

☐ GASTRIC EMPTYING SCAN

☐ LUNG SCAN (V/Q)

☐ G.I. BLEED SCAN

☐ BRAIN DEATH SCAN

☐ Other Nuclear Medicine Procedure (please specify):

Nuclear Cardiology

MYOCARDIAL PERFUSION IMAGING (CARDIOLITE)

☐ TREADMILL

☐ 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.

☐ MUGA SCAN

No patient preparation required.

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

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

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