Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING DEPARTMENT – **IVR**

Ordering Physician (please print):

Ordering Physician (signature):

Ordering Physician Contact #:

Date of Referral:

Copies To:

Patient Name:

DOB:

HCN:

Phone/Cell #:

Address:

☐ WSIB #:

☐ Pregnant - Yes

FAX to 613-354-4331

To book exam call: 613-354-3301 ext. 263.

A booking cannot be made unless this requisition is completed in full.

IF an exam is requested because of abnormalities found on imaging studies performed at a facility other than LACGH, the relevant reports and imaging studies must accompany the requisition or patient.

Clinical Information **(If an urgent same day procedure is required, please contact the Radiologist)**

*Incomplete and illegible requisitions will be returned *C-Arm table weight restriction 450 lbs

☐ Urgent (24 Hours) ☐Non-Urgent ☐ ED Patient in Hospital ☐ ED Patient sent home ☐ Inpatient

INTERVENTIONAL RADIOLOGY PROCEDURES

If on Coumadin/Coagulopathy/ Liver Disease <24 hour INR & Platelets: ______________________________

For Joint Injections:
Is prescription filled: ☐ YES ☐ PRESCRIPTION GIVEN

Home Care Arranged
(For Patients with PICCs): ☐ YES ☐ NO

- ☐ PICC Insertion
- ☐ PICC Exchange
- ☐ Shoulder Injection - Fluoroscopic
- ☐ Hip Injection – Fluoroscopic
- ☐ Paracentesis
- ☐ Thoracentesis

PATIENT INFORMATION

Breast Feeding	☐ YES ☐ NO
Liver Disease/Coagulopathy	☐ YES ☐ NO
Allergic to X-ray dye If yes, specify reaction:__________	☐ YES ☐ NO
Other Allergies: If yes, specify: ___________	☐ YES ☐ NO
On Anticoagulants If yes, specify:_________	☐ YES ☐ NO
On ASA/NSAIDs/Anti-Platelets If yes, specify:_________	☐ YES ☐ NO

PATIENT COMPETENCY

If patient is unable to provide consent they must be accompanied by SDM.

SDM Name: _____________

Office use only: Appt Date & Time

Please do not wear any scented products. Patient is required to bring this requisition and Ontario Health card.