Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING– **IVR**

**Tel: 613-354-3301 x263**

Patient Name:

DOB:
HCN:
Address:

Phone/Cell #:

WSIB #:

[Affix patient label here]

Physician Name: ___________________________

Physician Signature: ___________________________

Physician Contact #: ___________________________

Date of Referral: ___________________________

Report Copies To: ___________________________

**. INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .**
**PLEASE FAX COMPLETED REQUISITION TO 613-354-4331**

☐ ER Patient in Hospital ☐ ER Patient Sent Home ☐ Inpatient/ICU ☐ CVC Outpatient ☐ Outpatient

**CLINICAL INDICATION:**

*C-Arm table weight restriction 450 lbs

**Requested date/time frame:** ____________________

*Note: DI Department triages requests based on provided history*

**P1** = Within 24hr **P3** = Within 10 days

**P2** = Within 48hr **P4** = Within 28 days

## INTERVENTIONAL RADIOLOGY PROCEDURES

☐ **PICC Insertion** ☐ **Paracentesis**

☐ **PICC Exchange**

☐ **PICC Removal** ☐ **Thoracentesis** ☐ **RT** ☐ **LT**

**Pain Injections:**

| | | |
|---|---|---|
| **Shoulder Joint** | ☐ **RT** | ☐ **LT** |
| **1st CMC Joint** | ☐ **RT** | ☐ **LT** |
| **Hip Joint** | ☐ **RT** | ☐ **LT** |
| **Knee Joint** | ☐ **RT** | ☐ **LT** |
| **Biceps Tendon Sheath** | ☐ **RT** | ☐ **LT** |
| **De Quervain's Tendon Sheath** | ☐ **RT** | ☐ **LT** |
| **Subacromial Bursa** | ☐ **RT** | ☐ **LT** |
| **Trochanteric Bursa** | ☐ **RT** | ☐ **LT** |
| **PreAchilles/Retrocalc. Bursa** | ☐ **RT** | ☐ **LT** |
| **Plantar Fascia** | ☐ **RT** | ☐ **LT** |

For Injections (Depomedrol 40mg/80mg):
Steroid Prescription: ☐ FILLED ☐ GIVEN TO PATIENT
For PICCs:
Home Care Arranged: ☐ YES ☐ NO

## PATIENT INFORMATION

**Please Note: Patients receiving below waist pain injections will require a driver post procedure.**

**If on Coumadin/ Coagulopathy/ Liver Disease <24 hour INR & Platelets:** ____________________
*Please include faxed copy of bloodwork results*

Breast Feeding ☐ YES ☐ NO
Allergic to X-ray dye ☐ YES ☐ NO
If YES, specify reaction:________________
Other Allergies: ☐ YES ☐ NO
If YES, specify: ________________
On Anticoagulants ☐ YES ☐ NO
If YES, specify:________________
On ASA/NSAIDs/Anti-Platelets ☐ YES ☐ NO
If YES, specify:________________

## PATIENT COMPETENCY

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

SDM Name: ____________________

**Appointment Date:** **(DD/MM/YY) Time:** **Date Received:** **Date Notified:**