St.Thomas Elgin General Hospital

NUCLEAR MEDICINE REQUISITION

Affix Patient Label

1. PATIENT INFORMATION (attach label or Complete)

Last Name: _____

First Name: _____ Middle Initial: _____

Preferred Name: _____

Gender: _____ DOB (Y/M/D): _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____

Alternative Phone: _____

2. INSURANCE / BILLING

Health Card number: _____

Version code: _____

WSIB#: _____

Accident date: _____

CRIC#: _____

Other: _____

3. REFERRED BY

Name: _____

OHIP Billing # _____

Telephone #: _____

Fax #: _____

CC Physician: _____

Date: _____

Signature: _____

4. CLINICAL INDICATION

Height: _____cm Weight: _____kg

Pregnancy / Breastfeeding YES ☐ NO ☐

5. IMAGING & FUNCTIONAL STUDIES REQUESTED

CARDIAC:

Myocardial Perfusion

- ☐ Exercise Treadmill
- ☐ Pharmacologic Stress

☐ Wall Motion with Ejection Fraction (MUGA)

ENDOCRINE:

☐ Parathyroid

GI:

Biliary Scan (HIDA)

- ☐ HIDA (Post Cholecystectomy)
- ☐ HIDA (Cholecystitis)

☐ GI Bleed

☐ Meckel's Scan

☐ Gastric Emptying (Only Solid Performed)

OTHER (please specify): _____

LUNG:

☐ Perfusion Scan (PE/CTEPH)

LYMPHOSCINTIGRAPHY / SENTINEL NODE:

- ☐ Left Breast
- ☐ Right Breast
- ☐ Bilateral Breast
- ☐ Melanoma: _____

RENAL:

- ☐ Routine Renal
- ☐ Diuretic Renal

SKELETAL:

☐ Bone Scan

INFECTION/TUMOR IMAGING:

☐ Gallium