



IMAGING REQUISITION
NUCLEAR MEDICINE/ BMD

Name: _____
ID Number: _____ DOB: _____
Pt. Phone Number: (____) _____ HC # _____

EXAM INFORMATION:

Location: Stratford Medical Imaging – W1-300 Nuclear Medicine Register at Patient Registration West Building	Phone: 519-272-8212	Fax: 519-272-8247
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DEPARTMENT USE ONLY:

Place appointment sticker here	Is this Patient: <input type="checkbox"/> An Inpatient <input type="checkbox"/> In Isolation <input type="checkbox"/> From a long term care Home (ie. Nursing home) _____
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Clinical Information (**mandatory**):

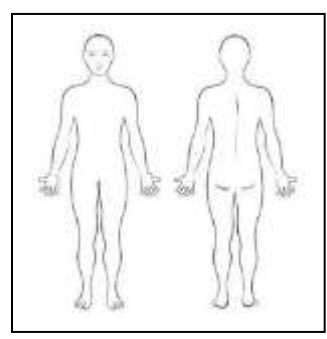
_____ PRIORITY DICTATION

Physician Name (please print): _____ Physician's Signature (**mandatory**) _____ Date _____

Additional Copies to: _____

Nuclear Medicine (Stratford)

- GENERAL:**
- Bone Scan
 - Lung V/Q
 - Hepatobiliary (HIDA)
 - Gastric Emptying
 - Thyroid Uptake/Scan
 - Thyroid Treatment
 - Parathyroid Scan
 - GI Bleed
 - Meckel's Scan
 - Gallium Scan
 - RBC Liver Scan (hemangioma)
 - Sulphur Colloid Liver/ Spleen Scan
 - Spect CT- Parathyroid
 - Melanoma Sentinel Lymph Node: site _____



(indicate area of concern on diagram)

- RENAL:**
- Renal Function
 - Lasix
 - Captopril
 - DMSA Scan (scarring)
- CARDIAC:**
- Stress Myocardial Perfusion
 - Treadmill
 - Pharmacologic
 - Thallium (Viability)
 - Wall Motion (MUGA)

Technologist Use Only:

* **Sentinel Lymph Node Localization (Breast lesion use BAC requisition)**

Bone Densitometry

- DEXA Bone Mineral Density (Clinton or Stratford) – (Please attach previous BMD reports)