London Health Sciences Centre

☐ University Hospital
☐ South Street Hospital
☐ Victoria Hospital

# NUCLEAR MEDICINE CONSULTATION

**Outpatient Appointment Date** (YYYY/MM/DD): _____

**Appointment Time:** _____

**Outpatient Bookings:**

University Hospital: Tel: 519-663-3433 Fax: 519-663-3860
Victoria Hospital: Tel: 519-685-8770 Fax: 519-667-6826
VH Departmental Inquiries: Tel: 519-685-8500 ext. 52985 Fax: 519-685-8290

Patient Type: ☐ IP ☐ OP ☐ Emerg ☐ Research Number: _____
☐ Ins/Legal Name: _____

Patient Pregnant: ☐ Yes ☐ No

PIN: _____ UNIT: _____ ROOM #: _____

NAME: _____ (Last) (First)

ADDRESS: _____

SEX: _____ BIRTH DATE: _____ (YYYY/MM/DD) AGE: _____

OHC#: _____ VERS. CODE: _____

PHYSICIAN: _____

**RELATIONSHIP OF PATIENT TO SUBSCRIBER:** ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD**

Copy to other physician? ☐ Yes ☐ No
If yes, Name: _____
Referring Physician OHIP# (if new): _____

☐ WSIB Claim#: _____ Date of Injury (YYYY/MM/DD): _____
Employer: _____
Employer's Address: _____

**Reason for referral with significant history, physical, laboratory findings and medications:**

**For Cardiac Stress Tests: Attach copy of recent ECG and consult note.**

**Procedure Requested**

Date (YYYY/MM/DD): _____

Requesting Physician's Signature: _____
Name (with initials) ***must*** be legible.

**For Nuclear Medicine Use Only:**