LR

IMAGING REQUISITION

IMAGE GUIDED BIOPSY OR DRAIN OUTPATIENT

(NOT FOR BREAST/THYROID/ PROSTATE)

Name:____

ID Number: ________________ DOB: ______________________

Pt. Phone Number: (___)__________ HC #________________

Clinical Information **(mandatory)**: ____

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____ ☐ PRIORITY DICTATION

Physician Name (please print):______________________ ______________________________

Physician's Signature (mandatory)

Additional Copies: __________________ ______________________

Date

Is this patient:

- ☐ An Inpatient
- ☐ In Isolation
- ☐ From a long term care home (ie. Nursing home)

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MANDATORY INFORMATION

Previous Imaging: ☐US ☐CT _____________ @ SGH or ____________________________________

Procedure discussed with MI: Dr. ______________or ________________________

Is this patient on Anticoagulants? ☐No ☐Yes Please specify drug, dose and reason for anticoagulation: ________________

____

Is it necessary to bridge the anticoagulation? ☐ No ☐ Yes What physician will manage this? ____________________

Other health issues of concern: ☐ Cardiac ☐ Renal ☐ Respiratory ☐ O2 dependent ☐ Mobility ☐ Hoyer lift ________________

Can the patient consent for the procedure? ☐Yes ☐ No --If not, who is the Power of Attorney? ____________________

(Full name and contact #)

APPOINTMENT INFORMATION

Date: ________________________**Time:** _________ a.m. p.m.

☐ Your patient has been notified of this appointment.

☐ Please notify your patient of appointment. Note required prep and registration location.

- ☐ **Register in Medical Imaging 1st floor East Building North**
- ☐ **Register in Surgical Services 2nd floor East Building North**
- ☐ **Please notify the POA that they must be present at time of Procedure**

PREP INFORMATION:

- ☐ No prep required
- ☐ Nothing to eat or drink past midnight
- ☐ Please come with a driver
- ☐ See attached Prep sheet

IMAGING DEPARTMENT USE ONLY:

MI Clerical to enter: ☐US ☐CT of _____________ ☐US ☐CT ☐Guidance ☐Biopsy of liver

☐ ABSCESS DRAINAGE

Request approved by Radiologist: _____________ Date ___________________________

Stratford Medical Imaging Ph 519-272-8212 Fax 519-272-8247 Procedural Nurse Ph 519-272-8210 Ext 2346