Timmins and District Hospital / Hôpital de Timmins et du district
John P. Larche Medical Imaging & Cardiopulmonary Department
Service d'imagerie médicale et de soins cardio-pulmonaires John P. Larche
Phone: 705-267-6312 | Fax: 705-267-6346 | E-mail: imaging@tadh.com

**HOSPITAL USE ONLY**

Patient Name: _____

Date of Birth: _____ (dd / mm / yyyy) Weight (lbs/kg): _____ (for medication on some procedures)

Address: _____ Apt. #: _____

City: _____ Postal Code: _____

Phone (Home): _____ Work: _____

Health Card #: _____

SIN #: (for WCB Claims) Claim #:

**PRECAUTIONS**

DROPLET ☐

AIRBORNE ☐

CONTACT ☐

**Allergies:**

**Enter ALL pertinent clinical information:**

**Maximum Patient Weight for most equipment is 300 lbs / 139 kg**

(Please Print or use Stamp) **Ordering Physician:** Date:

**Physician Signature:**

**CLINICAL INDICATION FOR SCAN**

BC ☐ MRI Breast Screening | OT ☐ Other | SD ☐ Cancer Staging/Diagnosis

**FOR RADIOLOGIST USE ONLY/RESERVÉ AU RADIOLOGUE**
**DIAGNOSTIC IMAGING - MRI and CT Priority Assessment Tool**

| Priority Level | Descriptions | Access Target |
|---|---|---|
| 1 ☐ | Emergent | Immediate |
| 2 ☐ | In-Patient<br>Urgent | Within 48 hours |
| 3 ☐ | Semi-Urgent | Within 10 days |
| 4 ☐ | Non-Urgent | Within 4 weeks |

| | | |
|---|---|---|
| **Copy to Family Physician:** | Dr. | Tel. # |
| **Copy to other Physician:** | Dr. | Tel. # |

**The above information must ALL be completed and be legible, or the requisition will be returned to the ordering physician.**

**X-Ray:** 1. _____ 2. _____ 3. _____ 4. _____

**Bone Densitometry (DPX):** ☐ Low Risk: ☐ High Risk: ☐ Baseline (1st BMD): Date of Previous DPX:

**Ultrasound:**

| | | | |
|---|---|---|---|
| ☐ Abdominal & Pelvic Ltd. | ☐ Obstetrical/LMP: Required | ☐ Groin ☐ Rt ☐ Lt | ☐ Scrotum |
| ☐ Abdominal | ☐ BHCG - Quantitative: Required | ☐ Prostate Biopsy | ☐ Thyroid |
| ☐ Pelvic | ☐ Endorectal Prostate PSA #: Required | ☐ Other _____ | |

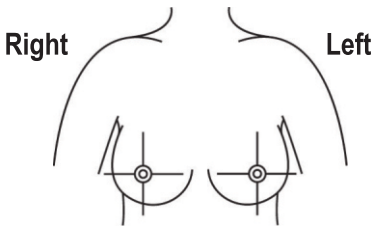
☐ Peripheral Arterial Doppler
☐ Venous Doppler ☐ Carotid Doppler
☐ Leg ☐ Arm ☐ Rt ☐ Lt
Physician Contact # _____

☐ Carotid Doppler

**Breast Imaging:**

Implants: ☐ Yes ☐ No | Date of Previous:

☐ Screening Mammogram (No signs or symptoms)
☐ Diagnostic Mammogram ☐ Rt ☐ Lt
☐ Breast Ultrasound ☐ Rt ☐ Lt
☐ Biopsy / Other (Needle localization, cyst aspiration)




**Nuclear Medicine:**

| | | | |
|---|---|---|---|
| ☐ Bone Scan | ☐ Meckel's Scan | ☐ Renal Scan | ☐ Parathyroid Scan |
| ☐ Gallium Scan | ☐ Gastric Emptying / Solid | ☐ Renal Scan with Lasix | Sentinel Node Scan RT ____/ LT ____ |
| ☐ Stress MIBI | ☐ RBC - GI Bleed | ☐ Renal Scan with Captopril | Thyroid Therapy I 131 |
| ☐ Persantine MIBI | ☐ HIDA Scan with EF% | ☐ Thyroid Uptake and Scan | Stat: _____ |
| | ☐ Lung Scan VQ | ☐ Muga Scan | |

**Department Use Only**

| ☐ Insulin Pump<br>☐ Glucose Monitor/Sensor | Tech Initials | Patient's Risk of Pregnancy | LMP | Patient's Initials | Examination Date Day | Month | Year | # of Images | ☐ In Patient<br>☐ Out Patient<br>☐ Portable |
|---|---|---|---|---|---|---|---|---|---|
| | | ☐ Yes<br>☐ No | | | | | | | |

**The following exams require a scheduled appointment.**

**Requisitions must be sent by courier or faxed to 267-6346 to be scheduled.**

Barium Enemas
Bone Densitometry
CT
Echo
GI Series
IVP
Mammograms
MRI
Nuclear Medicine
Special Procedures (ie. Biopsy, myelogram, angiogram, etc.)
Ultrasound
PFT, Holter tests, EEG

**CLERICAL BOOKING NOTES I.E,. messages left, rebooks, comments, patient communication**

_____

_____

_____

**NM**

| | | |
|---|---|---|
| **HIDA** — 4 hrs NPO | Yes ☐ | No ☐ |
| - Demerol | Yes ☐ | No ☐ |
| **Gastric Emptying/Fasting** | Yes ☐ | No ☐ |
| **Thyroid Scan** —Off Thyroid Meds | Yes ☐ | No ☐ |
| TSH Blood Work | Yes ☐ | No ☐ |
| **Captoril Renal** | | |
| Off BP Meds | Yes ☐ | No ☐ |

**MAMMO / DPX**

Previous Study: Yes ☐ No ☐

Date: _____ Location: _____

**ULTRASOUND**

**1.** Abdo Fasting: Yes ☐

**2.** Pelvic

Drink Start time _____ Drink End Time _____

**3.** Miscellaneous: No Prep Arrival Time: _____

**ALL PATIENTS**

L.M.P. _____ WEIGHT: _____

ALLERGIES: _____

**Booking Clerks Initials:** _____

**Ontario Breast Screening Program (OBSP)**

If the patient is:

- **50 years of age and over**
- **no acute breast symptoms**
- **no personal history of breast cancer**
- **have not had a mammogram within the past 12 months**
- **no history of breast implants**

If the patient meets all of the above criteria, she can be directed to the Ontario Breast Screening Program (OBSP). The patient will receive a screening mammogram. Please call 360-6012 for an appointment.

**Please ensure that the requisition is fully completed, signed and legible to prevent delaying the procedure for the patient. Requisitions will be returned to the ordering physician for missing information, missing signature or if not legible.**