Peterborough Regional Health Centre
Diagnostic Imaging Services – Angio Suite
INTERVENTIONAL RADIOLOGY REQUISITION-OUTPATIENT
Fax (705) 876-5070

CONSULTATION FOR INTERVENTIONAL RADIOLOGY - OUTPATIENT

Isolation: No ☐ Yes ☐ **Type of Isolation:** Contact ☐ Droplet Contact ☐ Airborne ☐

OUTPATIENT Male ☐ Female ☐ DOB: (dd/mm/yyyy)

Last Name: First Name:
Address:
City: Postal Code
Phone: (H) (W) Health Card #

Requested Procedure:

Indication for Procedure:

➔ INCOMPLETE OR ILLEGIBLE REQUISTIONS WILL BE RETURNED ➔
THEREFORE DELAYING THE BOOKING PROCESS

Physician Signature: ________________________
Printed Name: ______________________________
Physician Contact #:__________________________
Report to: _________________________________
Request Date: ______________________________

Is Patient Anticoagulated: No ☐ Yes ☐
If **YES**, is patient taking: (Circle choice)
ASA, Plavix, Coumaddin, IV Heparin, LMW Heparin

Is Patient Diabetic: No ☐ Yes ☐
Insulin Dependent No ☐ Yes ☐
Metformin No ☐ Yes ☐

Additional information requested by Interventional Radiologist

Current Bloodwork within 60 days of exam
INR _____ Platelets _____ APTT _____
HGB_____ CREATININE_____ Weight:_____

Creat. Clearance_____ Date of Bloodwork:

Previous Contrast Allergy: No ☐ Yes ☐
If **YES**, explain:

Is Patient able to give informed Consent:
No ☐ Yes ☐ If **NO**, please have POA accompany patient

Radiologist Coding Area:

D.I. Safety Checklist Completed: No ☐ Yes ☐

Received:

Booked:

Notified: