Request for Vascular or Interventional Radiology

☐ Outpatient ☐ Inpatient ☐ ED loc. __________

☐ **BIRCHMOUNT**
3030 Birchmount Road
Scarborough, ON M1W 3W3
Phone 416-495-2480
Fax 416-495-2619

☐ **CENTENARY**
2867 Ellesmere Road
Scarborough, ON M1E 4B9
Phone 416-281-7299
Fax 416-281-7493

☐ **GENERAL**
3050 Lawrence Avenue East
Scarborough, ON M1P 2V5
Phone 416-431-8167
Fax 416-431-8141

PATIENT INFORMATION

Name ______________________________ (*Last name, First name*) Date of birth ______________ (*Day-Month-Year*) Sex ☐ F ☐ M ☐ Other

Health card ______________________ Version code ______ Hospital ID ______________________

Address ____

City ______________ Postal code __________ Phone 1 ______________ (*Preferred*) Phone 2 ______________ (*Alternate*)

SCREENING

NEPHROPATHY

- Age > 60 .... ☐ Y ☐ N
- Diabetes .... ☐ Y ☐ N
- Hypertension requiring medication .... ☐ Y ☐ N
- Renal transplant or single kidney .... ☐ Y ☐ N
- Renal surgery or renal cancer .... ☐ Y ☐ N
- Dialysis .... ☐ Y ☐ N

If any nephropathy risk factor, provide:

eGFR ________ Test date (< 6 wks) ______________ (*Day-Month-Year*)

PRECAUTIONS

- Patient weight .... ________ kg
- Chance of pregnancy .... ☐ Y ☐ N
- Capacity to provide consent .... ☐ Y ☐ N

If no, provide SDM name and phone: ______________________

- Allergy to IV contrast .... ☐ Y ☐ N

If prior mild or moderate adverse reaction, referring physician to provide premedication for contrast procedures:

PREDNISONE 50 mg PO 13 h and 1 h before exam
DIPHENHYDRAMINE (e.g. BENADRYL) 50 mg PO 1 h before exam

HEMOSTASIS

aPTT ________ INR ________ Platelets ________

Test date (< 4 wks OP and < 2 wks IP/ER) ______________ (*Day-Month-Year*)

Non-target values must be corrected by the referring physician

- Antiplatelet or anticoagulant therapy .... ☐ Y ☐ N

If yes, specify ______________________

Specialist consultation recommended prior to withholding antiplatelet or anticoagulant therapy if any following risk factors:

- Stent inserted in previous 12 months .... ☐ Y ☐ N
- Atrial fibrillation .... ☐ Y ☐ N
- Intra-cardiac thrombus .... ☐ Y ☐ N
- Thrombotic episode in previous 3 months .... ☐ Y ☐ N
- Thrombotic episode during interruption of Warfarin .... ☐ Y ☐ N
- Severe thrombophilia .... ☐ Y ☐ N

PROCEDURE REQUESTED

CLINICAL INDICATION/RELEVANT HISTORY/PRIMARY DIAGNOSIS

Relevant imaging performed outside SHN must be uploaded to PACS

BILLING

☐ OHIP ☐ WSIB claim # ______________ ☐ Other ____________

REFERRING PHYSICIAN

Name, address, fax, phone, billing number:

Send copies to:

Signature ✗ ______________________ Date ____________

Form ID: 2618

Incomplete or unsigned requests will be returned and may result in delay

SHN
SCARBOROUGH HEALTH NETWORK

BOOKING PROTOCOL

1. Fax completed forms to the appropriate number for booking:
   - Birchmount Hospital 416-495-2619
   - Centenary Hospital 416-281-7291
   - General Hospital 416-431-8141

2. Procedures will only be booked upon receipt of a signed copy of this request form, previous relevant images/reports, bloodwork within target range and Interventional Radiologist approval.

A failure in correct completion will result in a booking delay.

3. The DI booking clerk will contact the Physician's office with the appointment and provide any additional instructions required for the procedure.

4. **Priority 1 or 2** requests require Interventional Radiologist consult, in addition to the indicated criteria.