Request for Vascular or Interventional Radiology

☐ Outpatient ☐ Inpatient ☐ ED loc. ________

☐ **BIRCHMOUNT**
3030 Birchmount Road
Scarborough, ON M1W 3W3

☐ **CENTENARY**
2867 Ellesmere Road
Scarborough, ON M1E 4B9

☐ **GENERAL**
3050 Lawrence Ave East
Scarborough, ON M1P 2V5

PHONE 416-431-8167 **FAX** 416-431-8103

Outpatient requests will be given first available at any department unless specified

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 __________

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