Request for Medical Imaging
Interventional Radiology

HUMBER RIVER HOSPITAL

Wilson Avenue Site
1235 Wilson Avenue, 2nd Floor
Toronto, ON M3M 0B2
TEL. (416) 242-1000 EXT 63311
FAX (416) 242-1078

Health Card No. _____

Last Name _____

First Name _____

Date of Birth (d/m/y) _____

Address _____

_____

Home Phone _____

Other Phone _____

Appointment Date: **Appointment Time:**

Interventional Examination Requested

- ❑ IJ LINE INSERTION
- ❑ PACEMAKER INSERTION
- ❑ ARM FISTULOGRAM
- ❑ TRANSJUGULAR LIVER BIOPSY
- ❑ IVC FILTER
- ❑ PTC
- ❑ PLEUR-X CATHETER INSERTION
- ❑ FALLOPIAN TUBE CANNULATION

- ❑ _____ TUBE (Specify Tube) INSERTION-REMOVAL-CHECK-EXCHANGE (Circle **One**)
- ❑ PORT-A-CATH INSERTION-REMOVAL-CHECK-EXCHANGE (Circle **One**)
- ❑ PICC LINE INSERTION-CHECK-EXCHANGE (Circle **One**)
- ❑ ARTERIO/VENOGRAM (Specify Vessel): _____
- ❑ EMBOLIZATION (Specify Vessel): _____
- ❑ ANGIOPLASTY (Specify Vessel): _____
- ❑ STENT INSERTION (Specify Vessel): _____
- ❑ ABSCESS DRAINAGE (Specify Location): _____
- ❑ VERTEBROPLASTY (Specify Levels): _____
- ❑ OTHER (Please Be Specific): _____

Clinical Indication for Exam

Physician Information

Physician's Name _____

Address _____

Phone _____ Fax _____

Physician's Signature × _____

Laboratory Results (< 30 Days)

INR: _____ Date: _____

PTT: _____ Date: _____

CBC: _____ Date: _____

Creatinine: _____ Date: _____

Platelets: _____ Date: _____

Patient Medication List

- ❑ Metformin
- ❑ Combination Medications (eg., Avandamet)
- ❑ Coumadin/Warfarin
- ❑ Other Anticoagulants: _____
- ❑ ASA (Please Specify Dose): _____
- ❑ Other: _____

Patient Medical Information

- ❑ Ambulatory
- ❑ Wheelchair
- ❑ Diabetic
- ❑ Cardiovascular Disease (eg., Hypertension)
- ❑ Respiratory Disease (eg., Asthma, COPD)

Weight (kg): _____

Allergies (**Especially X-ray/CT Contrast Material**):

_____

INCOMPLETE, ILLEGIBLE, AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED