

Request for Nuclear Medicine

Humber River Hospital
1235 Wilson Ave. LEVEL 1
Toronto, ON M3M 0B2



Phone 416-242-1000 Ext. 63823 Fax 416-242-1117

Appointment Information

Date _____ Time _____

Patient Information

Name _____
OHIP # _____ VC _____
DOB (d/m/y) _____ Sex M F
Address _____
City _____ PC _____
Phone _____

<p>Cardiac</p> <p><input type="checkbox"/> Exercise Stress Myocardial Perfusion <input type="checkbox"/> Persantine Stress Myocardial Perfusion (LBBB, Non-Ambulatory, Pacemaker) <input type="checkbox"/> Rest MUGA</p> <p>Patients must not have any caffeine 12 hours before any cardiac test.</p>	<p>Pulmonary</p> <p><input type="checkbox"/> Lung Scan <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Chest X-Ray PA-Lat (See Below) 24 hours 2 Views Chest X-Ray is required. Patients must bring images if done elsewhere.</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> GI Bleed <input type="checkbox"/> Meckel's Diverticulum <input type="checkbox"/> Gastric Emptying (See Below)</p> <p>Please inform the department if your patient has any allergy or sensitivity to eggs, wheat, and/or fruit.</p>
<p>Genitourinary</p> <p><input type="checkbox"/> Renal Lasix With MAG3 <input type="checkbox"/> Renal GFR <input type="checkbox"/> Renal Captopril <input type="checkbox"/> Renal MAG3</p>	<p>Hepatobiliary</p> <p><input type="checkbox"/> Biliary (HIDA) <input type="checkbox"/> Liver/Spleen <input type="checkbox"/> RBC Liver</p>	<p>Oncology/Infection/Inflammation</p> <p><input type="checkbox"/> Gallium Single Site _____ <input type="checkbox"/> Gallium Whole Body <input type="checkbox"/> Sentinel Node Lymphangiogram</p>
<p>Skeletal</p> <p><input type="checkbox"/> Bone Scan _____</p>	<p>Central Nervous System</p> <p><input type="checkbox"/> Brain Perfusion SPECT</p>	<p>Exocrine</p> <p><input type="checkbox"/> Salivary Glands</p>
<p>Diagnostic Endocrine</p> <p><input type="checkbox"/> Thyroid Uptake and Scan <input type="checkbox"/> Thyroid Malignancy Follow-Up <input type="checkbox"/> Parathyroid</p>	<p>Therapeutic Endocrine</p> <p><input type="checkbox"/> Thyroid I-131 Treatment _____ mCi <input type="checkbox"/> Thyroid Post Ablation Scan</p>	<p>Other Test Not Listed</p>

<p>Clinical Information</p>	<p>Supplementary Information</p> <p>Height _____ cm Weight _____ kg Table Weight Limit is 227 kg/500 lbs</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Pregnant, Breastfeeding <input type="checkbox"/> Y <input type="checkbox"/> N Diabetic <input type="checkbox"/> Y <input type="checkbox"/> N On Hemodialysis <input type="checkbox"/> Y <input type="checkbox"/> N Cancer (Specify Type) _____ <input type="checkbox"/> Y <input type="checkbox"/> N Assisted Care, Wheel-Trans <input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease <input type="checkbox"/> Y <input type="checkbox"/> N Allergies _____</p>
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<p>Referring Doctor Information</p> <p>Name (PRINT) _____ Address _____ City _____ PC _____ Phone _____ Fax _____ Signature _____ CPSO # _____ Billing # _____</p>	<p>Department Use Only</p> <p>Radiologist Code _____ Radiologist Comments _____ _____ _____ Radiologist Signature _____</p>
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INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITION FORMS WILL BE RETURNED



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Form # 002209, version (07-2019)

Scan	Preparation	Duration
Biliary (HIDA)	<ul style="list-style-type: none"> Nothing to eat or drink 4 hours before your test You may be asked to drink Ensure (supplied by the department) 	4.5 hours
Bone	<ul style="list-style-type: none"> No preparation is required 	4 hours
Brain	<ul style="list-style-type: none"> No alcohol or caffeine (ie., regular or decaffeinated coffee or tea, soda pop, chocolate, Codeine, any Tylenol) 12 hours before your test Bring a list of all your medications 	2 hours
Gallium	<ul style="list-style-type: none"> No preparation is required for Day 1 A bowel preparation may be required for Day 2 	Day 1 30 min Day 2 90 min 1-3 days between visits
Gastric Emptying	<ul style="list-style-type: none"> Nothing to eat or drink after midnight the night before your test Please inform the department if you have an allergy or sensitivity to eggs, wheat, and/or fruit Bring your Insulin and blood glucose monitor if you are diabetic 	5 hours
GI Bleed	<ul style="list-style-type: none"> No preparation is required 	Day 1 3 hours Day 2 30 min 1 day between visits
Liver/Spleen	<ul style="list-style-type: none"> No preparation is required 	1 hour
Lung	<ul style="list-style-type: none"> 2 Views Chest X-Ray is required within 24 hours of Lung Scan 	1 hour
Meckel's Diverticulum	<ul style="list-style-type: none"> Nothing to eat or drink 4 hours before your test Purchase and take two 75 mg tablets of Zantac 1 hour before your test You must not have had barium in the 3 days before your test 	1 hour
MUGA	<ul style="list-style-type: none"> No preparation is required 	1 hour
Myocardial Perfusion	<ul style="list-style-type: none"> No alcohol or caffeine (ie., regular or decaffeinated coffee or tea, soda pop, chocolate, Codeine, any Tylenol) 12 hours before your test You may have a light breakfast and you may bring a snack and/or lunch Wear comfortable clothes and shoes Bring a list of all your medications 	4 hours
Parathyroid	<ul style="list-style-type: none"> No preparation is required 	4 hours
RBC Liver	<ul style="list-style-type: none"> No preparation is required 	3 hours
Renal Captopril	<ul style="list-style-type: none"> No solid food 4 hours before your test Drink 3 glasses of water approximately 1 hour before your test Bring a list of all your medications 	2 hours
Renal Lasix/GFR/MAG3	<ul style="list-style-type: none"> No solid food 4 hours before your test Drink 3 glasses of water approximately 1 hour before your test Bring a list of all your medications 	1 hour
Salivary Glands	<ul style="list-style-type: none"> No preparation is required 	90 min
Thyroid Follow-Up	<ul style="list-style-type: none"> Nothing to eat or drink 2 hours before your test You will be given specific instructions by your doctor 	Day 1 30 min Day 2 60 min 2 days between visits
Thyroid I-131 Treatment	<ul style="list-style-type: none"> Nothing to eat or drink 2 hours before your test You will be given specific instructions by your doctor 	Treatment Dependent
Thyroid Post Ablation	<ul style="list-style-type: none"> No additional preparation needed to that of the treatment 	90 min
Thyroid Uptake and Scan	<ul style="list-style-type: none"> You must not have had iodinated contrast material in the 6 weeks before your test You must not have had vitamins with iodine, seaweed, kelp, iodine containing antiseptics, and/or cough medicine in the 4 weeks before your test You must not have had oral iodine solution in the 5 days before your test (eg., Lugol's, SSKI) Bring a list of all your medications 	Day 1 30 min Day 2 60 min 1 day between visits

Please talk to your doctor before stopping any medication(s).

Test duration is approximate and does not include the time you may be in the waiting room before your test.

Nuclear Medicine is located on Level 1 of the hospital next to the Central Elevators.

Please call 416-242-1000 Ext. 63823 if you have any questions.