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 _____

Cardiac

☐ Exercise Stress Myocardial Perfusion

☐ Persantine Stress Myocardial Perfusion
(LBBB, Non-Ambulatory, Pacemaker)

☐ Rest MUGA

Patients must not have any caffeine 12 hours before any cardiac test.

Pulmonary

☐ Lung Scan
☐ Routine ☐ Urgent

☐ Chest X-Ray PA-Lat (See Below)

24 hours 2 Views Chest X-Ray is required. **Patients must bring images if done elsewhere**.

Gastrointestinal

☐ GI Bleed

☐ Meckel's Diverticulum

☐ Gastric Emptying (See Below)

Please inform the department if your patient has any allergy or sensitivity to eggs, **wheat**, **and/or fruit**.

Genitourinary

☐ Renal Lasix With MAG3

☐ Renal GFR

☐ Renal Captopril

☐ Renal MAG3

Hepatobiliary

☐ Biliary (HIDA)

☐ Liver/Spleen

☐ RBC Liver

Oncology/Infection/Inflammation

☐ Gallium Single Site _____

☐ Gallium Whole Body

☐ Sentinel Node Lymphangiogram

Skeletal

☐ Bone Scan _____

Central Nervous System

☐ Brain Perfusion SPECT

Exocrine

☐ Salivary Glands

Diagnostic Endocrine

☐ Thyroid Uptake and Scan

☐ Thyroid Malignancy Follow-Up

☐ Parathyroid

Therapeutic Endocrine

☐ Thyroid I-131 Treatment _____ mCi

☐ Thyroid Post Ablation Scan

Other Test Not Listed

Clinical Information

Supplementary Information

Height _____ cm **Weight** _____ kg

Table Weight Limit is 227 kg/500 lbs

☐ Y ☐ N Pregnant, Breastfeeding

☐ Y ☐ N Diabetic

☐ Y ☐ N On Hemodialysis

☐ Y ☐ N Cancer (Specify Type) _____

☐ Y ☐ N Assisted Care, Wheel-Trans

☐ Y ☐ N Cardiovascular Disease

☐ Y ☐ N Allergies _____

Referring Doctor Information

Name (PRINT) _____

Address _____

City _____ PC _____

Phone _____ Fax _____

Signature _____

CPSO # _____ Billing # _____

Department Use Only

Radiologist Code _____

Radiologist Comments _____

Radiologist Signature _____

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITION FORMS WILL BE RETURNED

10060000006

Form # 002209, version (07-2019)

Scan	Preparation	Duration
Biliary (HIDA)	• 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	• No preparation is required	4 hours
Brain	• 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	• 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	• 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	• No preparation is required	***Day 1*** 3 hours ***Day 2*** 30 min 1 day between visits
Liver/Spleen	• No preparation is required	1 hour
Lung	• 2 Views Chest X-Ray is required within 24 hours of Lung Scan	1 hour
Meckel's Diverticulum	• 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	• No preparation is required	1 hour
Myocardial Perfusion	• 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	• No preparation is required	4 hours
RBC Liver	• No preparation is required	3 hours
Renal Captopril	• 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	• 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	• No preparation is required	90 min
Thyroid Follow-Up	• 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	• Nothing to eat or drink 2 hours before your test • You will be given specific instructions by your doctor	Treatment Dependent
Thyroid Post Ablation	• No additional preparation needed to that of the treatment	90 min
Thyroid Uptake and Scan	• 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.