Request for Interventional Radiology

Humber River Hospital
1235 Wilson Ave. **LEVEL 2 EAST**
Toronto, ON M3M 0B2
Phone 416-242-1000 Ext. 63311 ***Fax*** 1-855-325-7063

Appt. Date ________________ **Appt. Time** ________________

Patient Information

Name ______________________________
OHIP # ______________________ VC ________
DOB (d/m/y) ______________________ Sex ☐ M ☐ F
Address ______________________________
City ________________ PC ____________
Phone ______________________________

Tube/Catheter Device Procedures

1. Select Device

- ☐ Abscess Drain Tube
- ☐ Biliary Drain Tube
- ☐ Chest Tube
- ☐ Dialysis Catheter ____________
- ☐ Gastrostomy Tube
- ☐ Jejunostomy Tube
- ☐ Nephrostomy Tube
- ☐ Vascular Access Port
- ☐ PICC
- ☐ Other ________________

2. Select Procedure

- ☐ Insertion
- ☐ Removal
- ☐ Recheck
- ☐ Exchange

Non-Tube/Non-Catheter Device Procedures

Vascular

- ☐ Angiogram
- ☐ Coil Embolization
- ☐ Embolic Protection Device Insertion
- ☐ Embolic Protection Device Retrieval

Specify Vessel(s) ________________

Vertebral Augmentation

- ☐ Kyphoplasty
- ☐ Vertebroplasty

Specify Level(s) ________________

Renal

- ☐ Fistulogram With Angioplasty
- ☐ R ☐ L Nephostogram

Cardiac Pacemaker

- ☐ Single Lead Pacemaker Insertion
- ☐ Dual Lead Pacemaker Insertion
- ☐ Battery Pack Change
- ☐ Lead Change

Obstetric

- ☐ Fallopian Tube Cannulation

LMP (d/m/y) ________________

Other Test Not Listed

Clinical Information

Referring Doctor Information

Name (PRINT) ______________________________
Address ______________________________
City ________________ PC ____________
Phone ________________ Fax ____________
Signature ______________________________
CPSO # ____________ Billing # ____________

Supplementary Information

Height _______ cm **Weight** _______ kg

- ☐ Y ☐ N Pregnant, Breastfeeding
- ☐ Y ☐ N Diabetic
- ☐ Y ☐ N Hypertension
- ☐ Y ☐ N Other Cardiovascular Disease
- ☐ Y ☐ N Respiratory Disease
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N On Hemodialysis
- ☐ Y ☐ N Gout
- ☐ Y ☐ N Allergies ____________

Patient Medication List

- ☐ Y ☐ N Metformin
- ☐ Y ☐ N ASA _______ mg
- ☐ Y ☐ N Warfarin, Heparin
- ☐ Y ☐ N Apixaban, Rivaroxaban, etc.
- ☐ Y ☐ N Clopidogrel, Ticagrelor, etc.
- ☐ Y ☐ N Dabigatran
- ☐ Y ☐ N NSAIDs
- ☐ Y ☐ N Other ________________

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Patient Laboratory Test Results

Creatinine ____________ µmol/L
GFR ____________ mL/min/1.73m2
INR ____________
PTT ____________ sec.
Hb ____________ g/L
Platelets ____________ x 10^9/L
Hct ____________ L/L
CBC ____________ cells/mcl
Blood Collection Date (d/m/y) ________

Form # 103237, version (11-2020)

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