

# Request for Interventional Radiology

Humber River Health  
 1235 Wilson Ave. **LEVEL 2 EAST**  
 Toronto, ON M3M 0B2  
**Phone** 416-242-1000 Ext. 63313 **Fax** 1-855-325-7063



## Patient Information

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

Appt. Date \_\_\_\_\_ Appt. Time \_\_\_\_\_

### 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 Nephrostogram

#### Cardiac Pacemaker

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

#### Obstetric

- Fallopien 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 \_\_\_\_\_

### Patient Laboratory Test Results

Creatinine \_\_\_\_\_ μmol/L  
 GFR \_\_\_\_\_ mL/min/1.73m2  
 INR \_\_\_\_\_  
 PTT \_\_\_\_\_ sec.  
 Hb \_\_\_\_\_ g/L  
 Platelets \_\_\_\_\_ x 10<sup>9</sup>/L  
 Hct \_\_\_\_\_ L/L  
 CBC \_\_\_\_\_ cells/mcl  
 Blood Collection Date (d/m/y) \_\_\_\_\_

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



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