northern health
the northern way of caring

All Sites and Facilities

Nuclear Medicine Requisition

Last Name:
First Name (Preferred Name):
Encounter #: NH #: Chart Created: ☐ Yes ☐ No
DOB: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:
PATIENT LABEL

Department Use Only. Requisition Received Date: Time:	Appointment: Date: Time:

Important: "*" fields must be completed to avoid delays in patient processing

Patient Information

Last Name*:	First Name*:	Personal Health Number*:
Address*:	City *: Province: Postal Code:	Date of Birth*: YYYY-MM-DD
Primary Phone*: Alternate Phone*:	Height (cm)*: Weight (kg)*: Gender:	Interpreter Required: ☐ No ☐ Yes Specify Language:

Bill To: ☐ MSP Insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other: _____ ICBC/WSBC Number:

Mobility Requirements: ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift ☐ Walk ☐ Stretcher ☐ Bed ☐ Bariatric

Isolation precations:_____ Infection Concerns: ☐ VRE ☐ Active TB ☐ MRSA ☐ C.diff ☐ Other:_____

☐ Outpatient ☐ Inpatient ☐ ER ☐ ICU ☐ Other:

Ordering clinician timeframe request: (**Note:** Medical Imaging department will review with the relevant clinical information provided to determine the priority for scheduling the patient.)
☐ P1: within 24 hours ☐ P2: 2 to 7 days ☐ P3: 8 to 30 days ☐ P4: 31 to 60 days ☐ P5: specific date/follow up: _____

MI reviewed Priority P _____ Initials _____

The exams listed below can be booked with a diagnostic CT. Please choose from the following:

☐ Bone Scan +/- Diagnostic CT
Diagnostic CT of Body Part: _____
☐ Parathyroid Scan +/- Diagnostic CT
☐ Brain Scan +/- Diagnostic CT
☐ Iodine WB +/- Diagnostic CT (UHNBC/FSJ only)
☐ Octreotide Scan +/- Diagnostic CT
☐ Gallium Scan +/- Diagnostic CT

Other Nuclear Medicine Exams: ☐ Thyroid Uptake/Scan ☐ Renogram ☐ HIDA ☐ Gastric Empty ☐ MUGA
☐ WBC (UHNBC only) ☐ Liver RBC (Hemangioma) ☐ Liver/Spleen
☐ **MIBI** (UHNBC/FSJ to be ordered by internal medicine only)
Scan Date: _____
Nuclear Medicine Time: _____ Cardiac Lab Time: _____

Other Nuclear Medicine Exams (not listed above): _____
Therapy: _____
Previous Relevant Exams (including CT): _____
Date: _____ Previous Centre: _____

Clinical Findings / History / Clinical Question (must be legible)*:

Amended Physician Orders: As Discussed With:	Ordering clinician's name (print)*: _____ MSP #*: _____ Signature: _____ Copies to*: _____ Phone #*: _____ ☐ Urgent report requested

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PATIENT LABEL

FOR MEDICAL IMAGING USE ONLY:

MEDICAL IMAGING PRIORITIZATION AND COMMUNICATION

To be completed by Medical Imaging personnel:

☐ Radiologist required
Notes for booking staff:

To be completed by booking personnel:

Attempts to book:
1.

2.

3.

Notes:

Appointment date: _____ Time: _____

Technologist Comments:

Pregnant? ☐ No ☐ Yes LMP (YYYY-MM-DD): _____
IV Site: _____ by: _____ Shielding used: ☐ No ☐ Yes
IV Contrast: ☐ No ☐ Yes, _____ mL at _____ mL/sec
Injection time: _____ Tech initial: _____
DLP: _____

Contrast Info

INJ Sticker

Place flashcard label here