Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING– **IVR**

Tel: 613-354-3301 x263

Patient Name:

DOB:
HCN:
Address:
Phone/Cell #:

☐ Non OHIP Patient:

☐ WSIB #:

Physician Name: ______________________________

Physician Signature: ______________________________

OHIP Billing Physician Name/#:______________________________

Physician Contact #: ______________________________

Physician Fax #: ______________________________

Date of Referral: ______________________________

Report Copies To: ______________________________

. INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .
PLEASE FAX COMPLETED REQUISITION TO 613-354-4331

CLINICAL INDICATION:

*C-Arm table weight restriction 550 lbs/250 kgs

Requested date/time frame:

Note: DI Department triages requests based on provided history

P1 = Within 24hr
P2 = Within 48hr
P3 = Within 10 days
P4 = Routine

INTERVENTIONAL RADIOLOGY PROCEDURES

☐ **PICC Insertion** ☐ **Paracentesis**
☐ **PICC Exchange**
☐ **PICC Removal** ☐ **Thoracentesis** ☐ **RT** ☐ **LT**

Pain Injections:

Joint: Shoulder (glenohumeral)	☐ **RT**	☐ **LT**
Joint: 1st CMC	☐ **RT**	☐ **LT**
Joint: Hip	☐ **RT**	☐ **LT**
Joint: Knee	☐ **RT**	☐ **LT**
Tendon Sheath: Biceps (shoulder)	☐ **RT**	☐ **LT**
Tendon Sheath: De Quervain's	☐ **RT**	☐ **LT**
Bursa: Subacromial (shoulder)	☐ **RT**	☐ **LT**
Bursa: Gr. Trochanteric (hip)	☐ **RT**	☐ **LT**
Bursa: Retrocalcaneal/PreAchilles	☐ **RT**	☐ **LT**
Plantar Fascia	☐ **RT**	☐ **LT**

For Injections (**Depomedrol 40mg/80mg**):
Steroid Prescription: ☐ FILLED ☐ GIVEN TO PATIENT
For PICCs:
Home Care Arranged: ☐ YES ☐ NO

PATIENT INFORMATION

Please Note: Patients receiving below waist pain injections will require a driver post procedure.

If on Coumadin, <36 hour INR & Platelets needed.
Please include faxed copy of bloodwork results

On Anticoagulants, incl ASA ☐ YES ☐ NO
Specify:______________________

Allergic to X-ray/CT dye? ☐ YES ☐ NO
Specify reaction:______________

Other Allergies: ☐ YES ☐ NO
Specify: ______________________

Breast Feeding ☐ YES ☐ NO

PATIENT COMPETENCY

If patient is unable to provide consent they must be accompanied by SDM.

SDM Name: ______________________________

Appointment Date: **(DD/MM/YY) Time:** **Date Received:** **Date Notified:**