Hôpital Régional de Pembroke Regional Hospital

Diagnostic Imaging (DI) Requisition

Addressograph

PRH Telephone Number: (613) 732-4141, PRH DI MAIN Fax Number: (613) 732-6349
Computed Tomography (C.T.) & Nuclear Medicine Fax Number: (613) 633-4579

Examination(s) Requested:

Precautions:
☐ Contact ☐ Droplet ☐ Airborne ☐ Mask/Shield

Location of Patient:

Patient History and Pertinent Lab Results:

Mode of Transportation (In-Patients):
☐ wheelchair ☐ stretcher ☐ bed
☐ ambulatory ☐ portable ☐ fall risk

Oxygen required:
Yes No
☐ ☐

Patient Weight (kg)	**Patient Height (cm)**	**Allergies:**

Y	N	**Please check the following if applicable**
☐	☐	Renal impairment
☐	☐	Family history of End Stage Renal Disease
☐	☐	Dialysis Treatment
☐	☐	Metformin Treatment
☐	☐	Pregnant Beta-hCG level:

Y	N	**Contrast Nephropathy Risk Factors**
☐	☐	Diabetes Mellitus
☐	☐	Cardiac Disease
☐	☐	Hypertension
☐	☐	Nephrotoxic drugs:
☐	☐	Immunosuppression:
☐	☐	Collagen vascular disease
☐	☐	Dehydration, sepsis, shock

Y	N	**Possible MRI Contraindications**
☐	☐	Aneurysm surgery
☐	☐	Intraocular lens implant/Prior metal fragment
☐	☐	Eye surgery (excluding lens implants, cataract or laser)
☐	☐	Ear surgery (excluding ear tubes)
☐	☐	Cardiac Pacemaker
☐	☐	Implanted stimulators, electrodes, electronic devices
☐	☐	Any filters, stents, coils, grafts or shunts

Bone Density (BMD)
☐ Baseline (first BMD in Ontario)
☐ 2nd Low Risk (at 36 Months)
☐ 3rd Low Risk (at 60 Months)
☐ High Risk (once every 12 Months)

Creatinine Clearance or eGFR required for patients with ≥1 contrast nephropathy risk factors. Please provide the most recent value, date (within 3 months), and location of the test. Report required if test was not preformed at PRH.

MRI is contraindicated for all patients with pacemakers or defibrillators. Please forward operative report and specify the (stickers of make and model).

Breast Imaging:
Implants: ☐ Yes ☐ No
Last mammogram:
Date: Location:

Location:

Cr level:	eGFR level:	Date of test:

Device:	Date:	Institution of Surgery:

Ordering Practitioner (Print):
Signature:
Billing Number:

Office Telephone Number:
Fax Number:
Pager Number:

Copy of report to:
Address:
Fax Number:

OFFICE USE ONLY

Protocol:

Priority Code	**Protocolled by**	**eGFR Required?** ☐ **Yes** ☐ **No** ☐ **1m** ☐ **3m**	**Appointment Date:** **Time:**