BRANT COMMUNITY HEALTHCARE SYSTEM

INTERVENTIONAL RADIOLOGY REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9
BGH Ph: 519-751-5599 Fax: 519-751-5582

For Office Use Only:
Appointment Date/Time:

REFERRING CLINICIAN INFORMATION

Doctor's Name:	
OHIP Billing Number:	
Address	
City/Prov:	Postal Code:
Phone:	Fax:
Signature:	
Copies to:	

PATIENT INFORMATION

Health Card	Version	DOB (D D M M Y Y Y Y) / Sex (M F U)
First Name:	Last Name:	
Address:		
City/Province:	Postal Code:	
Phone Number:	Secondary Phone Number:	
WSIB Claim #:	Secondary Insurance:	
Patient Height:	Patient Weight:	

Does Patient Require Assistance? ☐Mechanical Lift ☐ Wheelchair ☐Language Interpreter - Specify

INTERVENTIONAL RADIOLOGY (APPOINTMENT REQUIRED) BGH Site Only

Oncology

☐L ☐R Hickman Line
☐L ☐R Port Line
☐ Single Port ☐ Double Port
☐ Biopsy – Organ: ____________
Site: ____________

Urology

☐L ☐R Kidney Mass Biopsy
☐L ☐R Nephrostomy
☐L ☐R Nephroureterostomy tube
☐L ☐R Ureteric Stent Insertion
☐ Suprapubic Catheter Insertion
☐ Suprapubic Catheter Change
☐L ☐R Nephrostogram
☐ Cystogram
Is bladder catheterized? ☐Y ☐N
☐ Urethrogram
☐ Nephrostomy Tube Exchange
Specify tube type: ____________

Thoracics

☐L ☐R Chest Tube Insertion
☐L ☐R Thoracocentesis
☐L ☐R Pleural Drain
☐L ☐R Lung Biopsy

Gastroenterology

☐ Percutaneous Gastrostomy
☐ Percutaneous Gastrojejunostomy
☐ Single Lumen☐ Double Lumen
☐ Tube Exchange – Specify tube type: ____________

Hepatobiliary

☐ Liver Biopsy
☐ Random ☐ Targeted
☐ Percutaneous Transhepatic Biliary Drain
☐ Cholecystostomy
☐ T – Tube Cholangiogram
☐ Paracentesis
☐ Other - Please specify:

Nephrology

☐L ☐R Kidney Biopsy
☐ Native ☐ Transplant
☐L ☐R Tunneled Dialysis Catheter
☐ Dialysis Line Exchange/ Fibrin Sheath Disruption

General Surgery

☐ Abscess Drainage
Organ: ____________
Site: ____________
☐ Fistulogram – Site: ____________
☐ Sinogram – Site: ____________
☐ Sialogram
☐ Joint Injection
Site: ____________
☐ Facet Joint Injection
☐ Lumbar Puncture
☐ Linogram
☐ Loopogram

PATIENT HISTORY

Can the patient sign consent? ☐Y ☐N

Contrast Allergy? ☐Y ☐N
Reaction: ____________

Drug Allergy? ☐Y ☐N
Reaction: ____________

CPAP, BIPAP, ventilator, forced air, trach? ☐Y ☐N
*If yes, patient must bring to the procedure.

Does the patient take any of the following antiplatelets/anticoagulants?

Coumadin (Warfarin)	☐Y ☐N
Rivaroxaban/Apixaban/Edoxaban	☐Y ☐N
Clopidogrel (Plavix)	☐Y ☐N
Dabigatran (Pradaxa)	☐Y ☐N
Ticagrelor (Brilinta)	☐Y ☐N
Acetylsalicylic Acid (Aspirin/ASA)	☐Y ☐N
Low Molecular Weight Heparin (eg. Dalteparin, Tinzaparin, Enoxaparin)	☐Y ☐N

Other:

Diabetes	☐Y ☐N
Renal Disease	☐Y ☐N
Hypertension	☐Y ☐N
Pregnancy/Breastfeeding	☐Y ☐N

Recent Lab Work (within 4 weeks)

INR ______ Platelets ______ Creat ______

Date Collected: ____________

CLINICAL HISTORY: REASON FOR ORDER

Related Previous Imaging: ☐CT ☐ MR ☐ US If yes, Where:

Please attach previous if not completed at BGH.

Please include all relevant patient history including previous reports or consult notes as appropriate.