Brant Community Healthcare System
The Willett, Paris
The Brantford General

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.