



BRANT COMMUNITY HEALTHCARE SYSTEM
NUCLEAR MEDICINE REQUISITION
 200 Terrace Hill St., Brantford ON N3R 1G9
 Tel: 519-751-5599 Fax: 519-751-5582

For Office Use Only:
 Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION	
Name:		Health Card	Version
OHIP Billing Number:		DOB	Sex
Address		First Name:	Last Name:
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:		WSIB Claim #:	Secondary Insurance:
Copies to:		Patient Height:	Patient Weight:
Does Patient Require Assistance? Mechanical Lift ☐ Y ☐ N Wheelchair ☐ Y ☐ N Language Interpreter ☐ Y ☐ N Specify: _____ Is the patient: Diabetic ☐ Y ☐ N Pregnant/Breastfeeding ☐ Y ☐ N Special Needs/Impairment ☐ Y ☐ N Specify: _____			
EXAM REQUESTED (BY APPOINTMENT ONLY) **INCOMPLETE REQUISITIONS WILL BE RETURNED**			
If urgent please provide physician call back number for results:			
CURRENT MEDICATIONS: (or attach list)			
CLINICAL HISTORY: REASON FOR ORDER			
Related Previous Imaging: ☐ Yes ☐ No If yes, Where: _____ Please attach previous if not completed at BGH.			
For Nuclear Medicine Use Only:			
Please include all relevant patient history including previous reports or consult notes as appropriate. Date Request Submitted: _____			