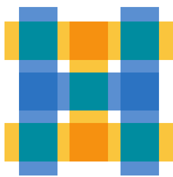

Department of Medical Imaging

Angiography Interventional Requisition

Phone: 416-756-6189 Fax: 416-756-6766

Patient Information

Name: ______________________ DOB: ______________________

Address: ____

Health Card: ______________________ MRN: ______________________

Phone: (H) ______________________ (W) ______________________

Procedure requested:
Relevant clinical findings: History (**MUST BE COMPLETED**)

Indicate previous exams
Include copies of any test reports

CT: ______________________

Ultrasound: ______________________

MRI: ______________________

X-ray: ______________________

Nuc. Med: ______________________

Other: ______________________

Referring MD: ______________ **Signature** ______________ Phys # ______________ CC ______________
(*required*)

Laboratory Data

INR __________ PTT __________ Plat __________

Creatinine ______________________

Date of lab test ______________________

Indicate medications taken by patient

- Meformin/Advantanet ❒
- Heparin ❒
- Coumadin/Warfarin ❒
- Plavix ❒
- Enoxaparin ❒
- ASA 81 mg ❒
- ASA 325/650 mg ❒

Is there a history of contrast allergy ❒Yes ❒No

Is the patient diabetic? ❒Yes ❒No

Does the patient speak English? ❒Yes ❒No
(If no, please ask patient to have an English-speaking person accompany them to the appointment to act as interpreter)

Making a World of Difference