NORTH YORK GENERAL
Making a World of Difference

Medical Imaging Department
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INTERVENTIONAL RADIOLOGY REQUISITION

FORM SF0357 **Page 1 of 1** **Rev. 04/2023**

Patient LABEL / Identification Area

Name: _____
Male ☐ Female ☐
MRN: _____
DOB: _____
Address: _____
Telephone: _____
Health Card Number #: _____

PROCEDURE REQUESTED

Relevant Clinical Findings (Mandatory):

Please attach all relevant imaging reports.

FOR OFFICE USE ONLY

Protocol Priority: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Specialty Codes: ☐ CS ☐ OT ☐ Timed

Modality: ☐ US ☐ CT ☐ Fluoro

Position: _____

Date: _____

Signature: _____

Appointment _____

BLOODWORK, COAGULATION PROFILE & RENAL FUNCTION, ANTIPLATELET/ANTICOAGULANT MEDICATION

Procedures are categorized as either Category 1 (low) or Category 2 (high) bleeding risk. Requirements for pre-procedural blood work and/or holding of antiplatelet or anticoagulation medications are based on these guidelines. These guidelines can be found on NYGH's website: Patient Information & Contacts | North York General Hospital (nygh.on.ca)

Certain patients undergoing procedures requiring intravascular contrast (e.g. angiography) require pre-procedural renal function screening, as per hospital policy. Please answer the following questions:

- ❒ History of renal disease (kidney transplant. Single kidney, renal surgery, dialysis, chronic renal failure, etc.)
- ❒ Has seen or is waiting to see a specialist due to decreased kidney function.

If the answer to the above questions is yes, renal function screening may be required.

Relevant bloodwork, if required

INR: _____ PTT: _____ Platelets: _____ Creatinine: _____ Date: _____

List all current antiplatelet and anticoagulant medication:

ALLERGY INFORMATION

Allergy to Iodinated Contrast? ☐ YES ☐ NO

If YES, describe reaction: _____

- **By the use and submission of this requisition, you are acknowledging that NYGH can use telephone, text message, or email communication to schedule and coordinate appointments.**
- **Interpreter required for non-English speaking patients**

REQUESTING PROVIDER

Address: _____

City: _____ Postal Code: _____

Telephone Number: _____

Fax Number: _____

OHIP Billing Number: _____

Copy to: _____

DATE/TIME	SIGNATURE (REQUESTING PROVIDER)	PRINT NAME
DD / Month / YYYY ____:__ __h		

Revised by Medical Imaging Manager 03/2023