London Health Sciences Centre

☐ University Hospital
☐ Victoria Hospital

NUCLEAR MEDICINE CONSULTATION

Outpatient Appointment Date (YYYY/MM/DD): ____________

Appointment Time: ____________

Outpatient Bookings:

University Hospital:	Tel: 519-663-3433	Fax: 519-663-3860
Victoria Hospital:	Tel: 519-685-8770	Fax: 519-667-6826
VH Departmental Inquiries:	Tel: 519-685-8500 ext. 52985	Fax: 519-685-8290

Patient Type: ☐ IP ☐ OP ☐ Emerg ☐ Research Number: ____________
☐ Ins/Legal Name: ____________

Patient Pregnant: ☐ Yes ☐ No

PIN: ____________ UNIT: ____________ ROOM #: ____________

NAME: ____________
Last First

ADDRESS: ____________

SEX: ______ BIRTH DATE: ____________ AGE: ______
YYYY/MM/DD

OHC#: ____________ VERS. CODE: ______

PHYSICIAN: ____________

RELATIONSHIP OF PATIENT TO SUBSCRIBER: ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD**

Copy to other physician? ☐ Yes ☐ No

If yes, Name: ____________

Referring Physician OHIP# (if new): ____________

☐ WSIB Claim#: ____________ Date of Injury (YYYY/MM/DD): ____________

Employer: ____________

Employer's Address: ____________

Reason for referral with significant history, physical, laboratory findings and medications:

PT= Wt: Ht:

For Cardiac Stress Tests: Attach copy of recent ECG, consult note and also provide the patient's height and weight.

Procedure Requested

Date (YYYY/MM/DD) : ____________

Requesting Physician's Signature: ____________
Name (with initials) must be legible.

For Nuclear Medicine Use Only:

NS5601 (Rev. 2011/06/16)