NUCLEAR MEDICINE REQUEST FORM

ST JOSEPH'S HEALTH CARE LONDON
268 Grosvenor Street
5th Floor, Room B5-204
Ph. 519-646-6000 Ext. 64137
Fx. 519-646-6135

Referred by: (PLEASE PRINT)

Physician's Name: _____

Phone Number: _____

Fax Number: _____

Patient Name: _____

Address: _____

City: _____ PC: _____

Phone No.: _____

DOB (yy/mm/dd): _____

INSURANCE:

OHIP NO.: _____ version code ( )

WSIB NO.: _____

ACCIDENT DATE: _____

OTHER: _____

CLINICAL PROBLEM: _____

_____

PREGNANCY/BREAST FEEDING? YES ___ NO ___

IMAGING (SCANS) & FUNCTIONAL STUDIES

SKELETAL:
- ___ BONE SCAN (req 3-5 hrs)
- ___ BONE MINERAL DENSITY – SPINE AND HIP
- ___ BONE MINERAL DENSITY – SPINE
- ___ BONE MINERAL DENSITY – HIP
- ___ BONE MINERAL DENSITY – WHOLE BODY

CARDIAC:
- ___ REST MYOCARDIAL PERFUSION
- ___ PHARMACOLOGICAL STRESS (dipyridamole or persantine)
- ___ STRESS – TREADMILL EXERCISE

WALL MOTION & EJECTION FRACTION:
- ___ REST

GI (NON-BILIARY):
- ___ LIVER SCAN
- ___ HEMANGIOMA LIVER SCAN (req 2-4 hrs)
- ___ SPLEEN (Tc RBCs) (splenic remnant/splenosis)
- ___ GI BLEED LOCALIZATION (for active bleeding)
- ___ GASTRIC EMPTYING (gastric motility)
- ___ MECKEL'S SCAN
- ___ H. PYLORI
- ___ LACTOSE INTOLERANCE

LUNG:
- ___ VENTILATION/PERFUSION
- ___ ASPIRATION STUDY
- ___ QUANTITATIVE PRE-OP

ENDOCRINE:
- ___ WB: THYROID CARCINOMA
- ___ PARATHYROID (req 2 hrs)
- ___ THYROID SCAN
- ___ THYROID UPTAKE
- ___ THYROID CONSULTATION

BRAIN:
- ___ ROUTINE SCAN (req 3 hrs)
- ___ TcHMPAO PERFUSION
- ___ CSF FLOW
- ___ V-P SHUNT
- ___ CSF LEAK

BILIARY:
- ___ ACUTE CHOLECYSTITIS
- ___ POST-CHOLECYSTECTOMY SYNDROME (CCK stimulated)
- ___ GALL-BLADDER CONTRACTILITY
- ___ BILIARY LEAK
- ___ NEONATAL

OTHER: _____

INFECTION/INFLAMMATION:
- ___ WHITE CELL SCAN (2 days) (abscess/localization)
- ___ GALLIUM SCAN
- ___ MARROW SCAN

KIDNEY: (req 2-3 hrs)
- ___ ROUTINE RENOGRAM
- ___ CAPTOPRIL RENOGRAM (for hypertension)
- ___ LASIX RENOGRAM
- ___ CORTICAL SCAN (DMSA)
- ___ GFR (DTPA)

THERAPY:
- ___ HYPERTHYROIDISM
- ___ THYROID CARCINOMA
- ___ P-32
- ___ YTRIUM KNEE THERAPY

LYMPHATIC:
- ___ LYMPHOSCINTIGRAPHY (Sentinel Node)
- ___ LYMPHOSCINTIGRAPHY (Routine)

REF. PHYSICIAN SIGNATURE: _____

DATE: _____