NM Nuclear Medicine (NM) Requisition

Providence HEALTH CARE

ST. PAUL'S HOSPITAL
Nuclear Medicine Department
1081 Burrard St., Vancouver, BC V6Z 1Y6

Appointments: 604-806-8008
Fax: 604-806-8075

MR MISS MRS MS	SURNAME	FIRST NAME	
PERMANENT ADDRESS			
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE
DATE OF BIRTH (MONTH / DAY / YEAR)		AGE	SEX
HEALTH CARE #	MSP ☐	WCB ☐	ICBC ☐ OTHER ☐

TO SCHEDULE AN APPOINTMENT PLEASE FAX OR MAIL COMPLETED REQUISITION TO NM DEPARTMENT. PATIENTS WHO DO NOT SPEAK ENGLISH MUST COME WITH AN INTERPRETER.

Appointment Date: _____ **Time:** _____

Please Check Exam Requested

☐ **Bone Scan**
- ☐ Extremity
- ☐ Non Contrast CT
- ☐ Other:_____

☐ **Myocardial Perfusion Scan (MIBI)**
Please complete Section A, B and C
- ☐ Proceed with Calcium Scoring if criteria met

☐ **Renal Scan:** *Please complete section A*
- ☐ Captopril ☐ Lasix

☐ **Thyroid Uptake and Scan:**
Please complete section A

☐ **Sentinel Node Localization:**
- ☐ Breast
- ☐ Other: _____

☐ **Parathyroid Scan**
- ☐ With Non Contrast CT

☐ **Labeled WBC Scan**

☐ **Other:** _____

PREGNANT? ☐ YES ☐ NO

CLAUSTROPHOBIC? ☐ YES ☐ NO
(If yes, please provide sedation as needed.)

ALLERGIES? ☐ NKA or _____

REASON FOR STUDY/HISTORY

SECTION A
Medications:
- ☐ Beta blockers
- ☐ Statins
- ☐ ACE Inhibitors
- ☐ Propylthiouracil
- ☐ Thyroid Hormone Replacement
- ☐ Other:_____

SECTION B
Diabetic: ☐ Yes ☐ No
- ☐ Previous MI *(Date and Location)*:_____
- ☐ Previous Angiogram *(Date and Location)*:_____
- ☐ Previous PCI/CABG *(Date and Location)*:_____
- ☐ Internal Cardiac Defibrillator *(If YES, upper rate limit)*:_____

SECTION C
Height: _____cm _____ins
Weight: _____kg _____lbs

Incomplete Requests will be Returned

_____ M.D. _____ PRAC. NO. _____
SIGNATURE OF AUTHORIZING PHYSICIAN PLEASE PRINT NAME

PHONE RESULTS: ☐ NO ☐ YES PHONE NO: _____ ADDITIONAL COPY OF REPORT TO: _____