North Bay Regional Health Centre
Diagnostic Imaging
Nuclear Medicine Requisition
Phone: (705)-474-8600 ext: 2820
Fax: (705) 495-7984

Patient Name:_____

Health Card #:_____

D.O.B.: _____

Phone #: _____

Patient requires a mechanical lift:	☐ No	☐ Yes	Patient Weight: _____ kg
Patient will be arriving via ambulance:	☐ No	☐ Yes	
Patient is pregnant or breastfeeding:	☐ No	☐ Yes	
Patient is currently on cytotoxic medications:	☐ No	☐ Yes	

PERTINENT CLINICAL HISTORY REQUIRED

Signature of Ordering Physician: _____Print Name of Ordering Physician: _____
☐Physician ☐ Resident ☐ Nurse Practitioner (restrictions applied for Nuclear Medicine Studies)
For non NBRHC physicians: Please include Ordering Physician # for billing purposes to avoid any delays in care

#_____**Address:** _____

- ☐ Amyloid Scan
- ☐ Bone Scan
- ☐ CSF Flow Scan
- ☐ CSF Shunt Scan
- ☐ Gastric Emptying Scan
- ☐ Gastro-Pulmonary Aspiration Scan
- ☐ Gastro-Intestinal Bleed Scan
- ☐ Hepatobiliary Scan
- ☐ Lung Scan (V/Q)
- ☐ Lung Scan Quantitative
- ☐ Liver / Spleen Scan
- ☐ Liver Scan for Hemangioma
- ☐ Meckel's Diverticulum Scan
- ☐ MUGA Scan (Cardiac Wall Motion)
- ☐ Myocardial Perfusion (MIBI) Stress Test
  Book with Cardio Respiratory Dept. Fax 705-495-8116
- ☐ Parathyroid Scan
- ☐ Renal Scan
- ☐ Renal Scan with Lasix™
- ☐ Salivary Gland Scan
- ☐ Sentinel Node Scan
- ☐ Thyroid Scan Only
- ☐ White Blood Cell Scan (WBC)
- ☐ Other_____

☐ **Thyroid Uptake and Scan**
☐ **I^{131} Therapy**
Thyroid Uptake/I^{131} Therapy: The patient must stop the following medications for the set time period prior to the test:
☐ Synthyroid / Eltroxin; **4-6 weeks**
☐ Propylthiouracil / Tapazole; **3 days**
Note: no kelp, seaweed, natural thyroid supplements or **CT with Contrast; 4 weeks**
Please check off appropriate box below:
☐ Patient is not on listed medications.
☐ Patient will discontinue listed medications for appropriate duration. **Please contact your patient to stop the listed medications before the test, if you feel it's safe.**

☐ **Renal Scan with Captopril™**
Renal Scan with Captopril: The patient should discontinue the following medications for 48 hours prior to the test:
☐ ACE Inhibitors
☐ Angiotensin II Receptor Blockers
☐ Alpha Blockers
☐ Calcium Channel Blockers
☐ Diuretics
Please check off appropriate box below:
☐ Patient is not on listed medications.
☐ Patient will discontinue listed medications for appropriate duration. **Please contact your patient to stop the listed medications before the test, if you feel it's safe.**

Office use only: Patient Contact: 1. Date:_____2. Date:_____3. Date:_____
Patient Notified: Date:_____ Clerk Initial:_____
Pt. Instructions given_____