

Waterloo Wellington Hospitals Nuclear Medicine Requisition

OFFICE USE ONLY

Exam Date:

Arrival Time:

Exam Time:

Fax completed requisition to ONE Hospital:

☐ Cambridge Memorial Hospital: (CMH) **519-740-4904**
☐ Guelph General Hospital: (GGH) **519-766-9982**

☐ Waterloo Regional Health Network
 @ Midtown: (WRHN-M)
 @ Queen's Boulevard: (WRHN-QB)

519-749-6997

****Please note that all Nuclear Medicine tests require a booked appointment**

Patient Information		Other Reqs Associated to Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	
Last Name, First Name: _____		Health Card #: _____	VC: _____
DOB: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		WSIB? <input type="checkbox"/> Y <input type="checkbox"/> N	Injury Date: DD/MM/YYYY
Street Address: _____		Please include Claim #: _____	
City/Town: _____		Other Insurance? Third Party or Self Pay	
Province: _____ Postal Code: _____		Specify: _____	
Contact Number: _____ Email: _____		Required Patient Information:	
Home: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		Height: _____ (cm)	Weight: _____ (kg)
Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		<input type="checkbox"/> Restricted Mobility	<input type="checkbox"/> Outpatient
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		<input type="checkbox"/> Pediatric Under 10 yrs	<input type="checkbox"/> In-patient Rm/Loc
<input type="checkbox"/> Y <input type="checkbox"/> N An interpreter is required to consent to the procedure.		<input type="checkbox"/> Patient Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Patient Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No
CMH, GGH, WRHN have interpretation services available.		<input type="checkbox"/> Patient Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please bring diabetic medications
EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUISITIONS WILL BE RETURNED**			
Clinical History/Indication (reason for exam)			
Select Region/Organ of Interest:			
CARDIAC Myocardial Perfusion <input type="checkbox"/> Exercise Treadmill <input type="checkbox"/> Pharmacologic stress <input type="checkbox"/> Rest Only Thallium Perfusion for viability (not performed at GGH) <input type="checkbox"/> Wall Motion (MUGA) <input type="checkbox"/> Cardiac Amyloid <input type="checkbox"/> Cardiac Shunt Right to Left GI <input type="checkbox"/> Biliary Scan Specify: _____ <input type="checkbox"/> Liver/Spleen <input type="checkbox"/> Liver Hemangioma <input type="checkbox"/> GI Bleed <input type="checkbox"/> Meckels Scan <input type="checkbox"/> Salivary Scan <input type="checkbox"/> Gastric Emptying (Not provided at CMH) <input type="checkbox"/> Solid <input type="checkbox"/> Liquid (GGH only)	SKELETAL <input type="checkbox"/> Bone Scan <input type="checkbox"/> Bone Marrow GU <input type="checkbox"/> Renal Routine - CMH/GGH WRHN - please choose one: <input type="checkbox"/> MAG 3 <input type="checkbox"/> DTPA <input type="checkbox"/> Renal Diuretic <input type="checkbox"/> Renal Captopril <input type="checkbox"/> Renal Cortical BRAIN (WRHN only) <input type="checkbox"/> Brain Perfusion SPECT <input type="checkbox"/> Cisternogram (CSF Flow) LUNG <input type="checkbox"/> Ventilation/Perfusion (VQ) <input type="checkbox"/> V/Q with Quantitation	ENDOCRINE <input type="checkbox"/> Thyroid Uptake/Scan <input type="checkbox"/> Thyroid Uptake Only _____ <input type="checkbox"/> Thyroid Scan Only For Thyroid requests, please answer: Is patient on thyroid medications <input type="checkbox"/> Y <input type="checkbox"/> N Is patient on multivitamins <input type="checkbox"/> Y <input type="checkbox"/> N Has patient had a recent CT with IV contrast <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Parathyroid <input type="checkbox"/> Thyroid Therapy (RAIU) (WRHN-QB Only) MISCELLANEOUS <input type="checkbox"/> Sentinel Node <input type="checkbox"/> Left Breast <input type="checkbox"/> Right Breast <input type="checkbox"/> Melanoma Implants <input type="checkbox"/> Y <input type="checkbox"/> N Specify: OR Date: _____ OR Time: _____ Infection/Neoplasm <input type="checkbox"/> Gallium Scan <input type="checkbox"/> White Cell Scan (not provided at CMH and GGH) OTHER <input type="checkbox"/> _____	
Ordering Physician Name (Please print): _____		Signature _____	URGENCY <input type="checkbox"/> Urgent <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> Routine
Contact #: _____	Fax#: _____	Date _____ Billing #: _____	
Copy to (Please print)			

Please indicate location of Nuclear Medicine examination for Patient:

Cambridge Memorial Hospital
700 Coronation Blvd.
Cambridge ON N1R 3G2

Telephone: 519-621-2333 x2245
Fax: 519-740-4904
www.cmh.org

- All patients are to register in the Diagnostic Imaging Department, located on the **1st Floor** of the hospital's **A Wing**, at the indicated arrival time.

Guelph General Hospital
115 Delhi St.
Guelph ON N1E 4J4

Telephone: 519-837-6413
Fax: 519-766-9982
www.gghorg.ca

- All patients are to register in the hospital's Diagnostic Imaging Department, located on the **3rd Floor**, at the indicated arrival time.

**Waterloo Regional Health Network
@ Midtown**
835 King St. W
Kitchener ON N2G 1G3

Telephone: 519-749-6495
Fax: 519-749-6997
www.wrhn.ca

- All patients are to register in the Department of Medical Imaging, located on the **2nd Floor** of the hospital's **D Wing**, at the indicated arrival time.

@ Queen's Boulevard
911 Queen's Blvd
Kitchener ON N2M 1B2

- All patients are to register in the hospital's Diagnostic Imaging Department, located on the **1st Floor**, at the indicated arrival time.

How to prepare for your Nuclear Medicine Examination

Type of Study	Patient Preparation	Expected Time	Visit Detail
BONE	No preparation	1 st Visit: 15 Minutes 2 nd visit: 1 hour	1 st visit: Injection 2 nd visit 2-4 hours later Imaging
BRAIN	Nothing to eat or drink 4 hours before test	2-4 hours	Injection upon arrival followed by Imaging
GALLIUM	No preparation	1 st Visit: 15 Minutes 2 nd visit: 1-2 hours	1 st visit: Injection 2 nd visit: Imaging
GASTRIC EMPTYING (GET)	<ul style="list-style-type: none"> • Nothing to eat or drink after midnight • Notify department if you have an allergy to eggs, food restrictions or are Type I diabetic • Diabetic patients, bring insulin and glucose monitor • Check with your doctor about stopping medications 	4 hours	Provided a standardized meal and Imaging up to 4 hours.
LIVER & SPLEEN SCAN	No preparation	45 minutes	Injection upon arrival followed by Imaging
LUNG SCAN (V/Q)	Need recent CXR 24-48 hours prior to lung scan (GGH only)	1 hour	Imaging immediately
MYOCARDIAL PERFUSION	Please refer to separate listing of instructions provided by your physician	1 st Visit: up to 2 hours 2 nd visit: up to 3 hours	Please refer to separate listing of instructions provided by your physician
PARATHYROID	No preparation	Up to 4 hours	Injection upon arrival 1 st imaging at 15 minutes 2 nd imaging at 3-4 hours
RENAL DIURETIC	Drink 3-4 glasses of fluids/water prior to test	1 hour	Injection upon arrival followed by Imaging
RENAL with CAPTOPRIL	<ul style="list-style-type: none"> • Check with your doctor about stopping medications • Drink 3-4 glasses of fluids/water prior to test • No food 4 hours prior to test • Bring a list of medications 	1 st Visit: 2 hours 2 nd visit: 45 minutes may be required based on results of 1 st visit	1 st Visit: Oral Captopril given upon arrival Injection at 1 hour followed by Imaging 2 nd Visit: Injection upon arrival followed by Imaging
SALIVARY	No preparation	1 hour	Injection upon arrival followed by Imaging
SENTINEL NODE	No preparation	2 hours	Injection upon arrival followed by Imaging
THYROID UPTAKE AND SCAN	<ul style="list-style-type: none"> • Check with your doctor about stopping medications • No CT contrast for 30 days prior to test 	1 st Visit: 15 minutes 2 nd visit: 45 minutes	1 st Visit: Pill ingestion 2 nd visit: Injection upon arrival followed by Imaging
WALL MOTION (MUGA)	No preparation	1.5 hours	Injection upon arrival followed by Imaging

Important

- Please bring your **Ontario Health Card** and this form to your appointment
- **Patients must be able to consent to the procedure. If language is a barrier, please bring an interpreter.**
- If you are unable to keep your appointment, please give us 48 hours' notice
- We kindly ask that you do not wear or apply fragrances in support of our Fragrance Free policies.