# Diagnostic Imaging Nuclear Medicine

William Osler Health System

Fax: 905-494-6618 ◯ Next available appointment **OR** ◯ Brampton Civic Hospital ◯ Etobicoke General Hospital

## Patient Information

Name:_____ Date of Birth*(DD/MM/YYYY)*:_____
Health Card No:_____ Version Code:_____
Address:_____ City:_____ Prov.:_____ Postal Code:_____
Tel:_____ Email:_____

To **request DI exam for discharged ED / UCC patient**, select time frame* for DI exam, and send patient with this requisition to the DI remote / EDDI desk to book DI exam. **Do not fax this requisition.** ◯ Less than 24h ◯ Less than 48h ◯ Less than 10 days ◯ Less than 1 month

## Examination Requested

**Bone Mineral Densitometry (DPX – Osteoporosis)**
- ☐ Baseline Exam - Initial visit (EGH & PMC Only)
- ☐ Low Risk 2nd visit (Not booked within 3 years of previous)
- ☐ Low Risk 3rd visit (Not booked within 5 years of previous)
- ☐ High Risk – Designated after 1st visit (Not booked within 1 year of previous)

**Bone Scan (3 to 4 hours)**
- ☐ Whole Body Bone scan
  Specify body part:_____

**Myocardial Perfusion**
- ☐ Low-Dose Exercise ** Patient weight:_____
- ☐ Persantine ** Patient weight: _____
- ☐ Thallium Rest / Redistribution
- ☐ Tc-Pyrophosphate (Cardiac Amyloidosis)
- ☐ Coronary Artery Calcium scoring

**** No Caffeine for 24 hours prior to scan**

**Endocrine**
- ☐ Thyroid Uptake and scan
- ☐ Parathyroid scan
- ☐ I 123 Iodine scan

**CNS**
- ☐ Brain SPECT
- ☐ CSF Flow study

**G. I.**
- ☐ Liver / Spleen scan
- ☐ Labeled Red Blood Cell Liver scan
- ☐ GI Bleeding scan*
- ☐ Meckels scan*
- ☐ Gallbladder (HIDA) scan*
- ☐ Gallbladder (HIDA) scan* with Ejection Fraction*
- ☐ Gastric Emptying Time with Esophageal Transit: Liquid*
- ☐ Gastric Emptying Time: Solid*
- ☐ Salivary scan
- ☐ Liquid Aspiration Study

***NPO 8 hours prior to scan**

**MUGA**
- ☐ Rest

**Gallium**
- ☐ Total Body
- ☐ Specific Site

**Respiratory**
- ☐ Ventilation / Perfusion Lung scan
- ☐ U/S Venous Doppler required for pregnant patients
- ☐ Quantitative Lung scan

**Genitourinary**
- ☐ Renal with Lasix
- ☐ Renal with GFR
- ☐ Renal with Captopril
- ☐ DMSA (BCH only)
- ☐ Nuclear Voiding Cystogram

**Miscellaneous**
- ☐ I 131 Whole Body scan
- ☐ Sentinel Node
- ☐ White Blood Cell scan
- ☐ Octreoscan
- ☐ Other: _____

## Clinical Questionnaire

Clinical History (Mandatory):

Imaging Work-up: Has relevant imaging of the area been performed at William Osler Heath System ◯ Yes ◯ No

Provider Name (Print): _____CPSO/OHIP Billing #: _____

Telephone: _____ Fax: _____

Copies to (Provider Name): _____

Provider Signature: _____Date :_____

**DI USE ONLY**

**Technical Information**

***Booking date is dependent on appointment availability and radiologist supervised clinical triaging based on provided clinical history**

**NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING**