Reset

DIAGNOSTIC IMAGING (BGH)- NUCLEAR CARDIOLOGY

NUC CARD

Quinte Health	MD Name:	Patient Name:
	Signature:	DOB:
	MD Phone :	HCN:
	Date: (d/m/y)	Home Phone:
FAX ALL REQUISITIONS TO: **613-969-5561**	Copies to:	Cell Phone
	WSIB #:	Address:

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:

Weight Limit 542 lbs.

Height:_____cm Weight:_____lbs.

****Radiopharmaceuticals for each NM procedure are ordered 24 hours in advance specifically for each patient. If cancellation of an appointment is necessary, please ensure the NM department is given at least 24 hours' notice, as there is a cost associated with radiopharmaceuticals and their delivery.**

PRIORITY: ☐ Urgent ☐ Non-Urgent ☐ Inpatient ☐ ER ☐ Outpatient

Myocardial Perfusion Scan ☐ **Exercise** ☐ **Dipyridamole** ☐ **Dobutamine** ☐ **Viability**

RELEVANT HISTORY:

Y	N		Y	N	
☐	☐	**MI Date:_____.**	☐	☐	**Stroke/TIA_ Date:**
☐	☐	**CABG**	☐	☐	**Recent PFT?**
☐	☐	**Angioplasty**	☐	☐	**COPD**
☐	☐	**Cardiomyopathy**	☐	☐	**Asthma**
☐	☐	**Arrhythmia/Pacemaker, Specify: _____**	☐	☐	**Diabetes**
☐	☐	**LBBB**	☐	☐	**Recent EST? (fax results)**

Y	N	
☐	☐	**PATIENT HAS RECEIVED NM CARDIAC INSTRUCTION SHEET?**

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613 969 5561

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ALLERGIES? ☐ **Y** ☐ **N**

Please List:

CURRENT MEDICATION LIST:

DEPARTMENT USE ONLY

Ensure patient receives NM Cardiac instructions.

☐ **THALLIUM**
☐ **TWO DAY**
☐ **SAME DAY**

☐ **EXERCISE (SIDE A)**
☐ **MODIFIED EX (SIDE B)**
☐ **DIP (SIDE B)**
☐ **DOBUTAMINE (SIDE A)**

Appointment Date & Time:

USE INSTRUCTION SHEET:

☐ **SIDE A** ☐ **SIDE B**

BMI:

Notes:

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613 969 5561