DIAGNOSTIC IMAGING – NUCLEAR MEDICINE

Nuc Med

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 INDICATIONS:

Height (cm): **Weight (kg):**

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

Allergies:

Pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

CARDIOVASCULAR:

- ☐ **Ventricular Function**

For Myocardial Perfusion please submit Nuclear Cardiology Requisition

RESPIRATORY:

- ☐ **Lung Vent and Perf (VQ)**
- ☐ **Lung Quantification**

GENITOURINARY:

- ☐ **Renal Study Routine**
- ☐ **Renal Study Diuretic**
- ☐ **Renal Study Captopril (Include Medication List)**
- ☐ **Renal Study DMSA**

ENDOCRINE:

- ☐ **Thyroid Scan (Thyroid Uptake)**
- ☐ **Parathyroid (BW required: PTH, Serum Ca, Vit. D)**
- ☐ **Endocrine Tumour Localization (Octreoscan, MIBG)**

SKELETAL:

- ☐ **Bone Scan Whole Body**
- ☐ **Bone Scan Specific Site**

GASTROINTESTINAL:

- ☐ **Liver Spleen Study**
- ☐ **RBC Liver Study**
- ☐ **Meckel's Search**
- ☐ **GI Bleed**
- ☐ **Cholescintigram**
- ☐ **Gastric Empty**
- ☐

MISCELLANEOUS:

- ☐ **Gallium Study**
- ☐ **Labelled WBC Study**
- ☐ **Sentinel Node Localization**
- ☐ **Other:**

DEPARTMENT USE ONLY:

Appointment Date & Time:

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