SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

REQUEST FOR DIAGNOSTIC IMAGING
Please Fax to SAH: 705-759-3714

I, _____ authorize Sault Area Hospital to leave a message by:
(Please Print Patient Name)

☐ Phone ☐ Email – Patient email: _____

Pt. Alternate Phone #:_____

WSIB Claim Number: _____ Employer: _____

Patient Signature: _____

Exam Requested:

MAMMOGRAPHY OBSP ext. 4709

☐ XRAY ☐ ULTRA SOUND ☐ NUCLEAR MED ☐ INTERVENTIONAL
(Complete information on back)

Procedure Requested: _____

Clinical Information Mandatory:

_____

_____

_____

_____

_____

_____

Referring Physician: _____
(Please Print Name)

Physician Signature: _____

Please Note: **CT and MRI Requests** to be ordered on respective requisitions.
(CT Form#12487) (MRI Form#12489)

Please Fax to SAH: 705-759-3714

Date and Time: Sep/19/2019 11:27

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Mandatory Information for Interventional Procedures:

Patient Weight: _____ Patient Special Needs: _____

Allergies: Radiographic Contrast ☐ Yes ☐ No
Latex ☐ Yes ☐ No
Heparin ☐ Yes ☐ No
Other: _____

PTT: _____ INR: _____ Order Date: _____ (With-in 3 Days)

CREATININE: _____ Order Date: _____ (With-in 1 month)

1. Does patient have palpable groin pressure: ☐ Right ☐ Left
   (necessary for peripheral angiograms and angioplasty)
2. Is patient diabetic (on Metformin, Glucophage or Advandamal) ☐ Yes ☐ No
3. Is Patient on Dialysis? ☐ Yes ☐ No If Yes, Days: _____
4. Is Patient on Anticoagulants ☐ Yes ☐ No Medication: _____

Approval for discontinuation of Anticoagulants ☐ Yes ☐ No

Physician's Name: _____
(Please Print Name)

Physician's Signature: _____

*** The ordering physician is the MRP post-procedure**

FOR DEPARTMENTAL USE ONLY

Date Received: _____ Assigned Appointment Date: _____ Initials: _____

Daycare Required: ☐ Yes ☐ No

Appointment Date: _____ Appointment Time: _____

Booked by: _____

Patient Notified by: ☐ Diagnostic Imaging

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Priority: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Date and Time: Sep/19/2019 11:27

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