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 #:_____

Patient Signature: _____

Exam Requested:

☐ MAMMOGRAPHY ☐ OBSP ext. 4709 ☐ CONTRAST MAMMOGRAPHY

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

Procedure Requested: _____

Clinical Information Mandatory:

_____

_____

_____

Include Lab Orders for any requested specimen:

_____

For Contrast Mammography *ONLY* - Does the patient have the following risk?

Does your patient have kidney disease, transplant or nephrectomy? ☐ Yes ☐ No
Has your patient seen or waiting to see a kidney specialist or urologist? ☐ Yes ☐ No

If you have checked "Yes" there is a risk of contrast induced nephropathy. A current eGFR is required *within 1 month* in order to have exam. Please Fax results to (705) 759-3714

Creatinine _____ eGFR _____ Date of Blood Test _____

Dialysis? ☐ Yes ☐ No
Adverse Reaction to Contrast Media? If yes, see SAH pre-medication protocol ☐ Yes ☐ No

Referring Physician:_____
(Please Print Name)

Physician Signature: _____ Date: _____

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Mandatory Information for Interventional Procedures:

Patient Weight: _____ Patient Special Needs: _____

Allergies: _____

1. Does the patient have palpable groin pressure: ☐ Right ☐ Left
   (Necessary for peripheral angiograms and angioplasty)
   ☐ PTT _____ ☐ INR _____ (please ✓ order to be done day of procedure at SAH)
2. Is patient on Anticoagulants ☐ Yes ☐ No Medication: _____

Approval for discontinuation of Anticoagulants ☐ Yes ☐ No Orders:_____

Estimated Due Date (EDD) or Last Menstrual Period (LMP): _____

Physician's Name:_____

(Please Print Name)

Physician Signature: _____

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

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

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: _____