Mackenzie Health
Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Patient Name:

Health Card No:

INPATIENT/OUTPATIENT VASCULAR AND INTERVENTIONAL RADIOLOGY REQUISITION

Diagnostics Imaging (Main Level) **IP** ☐
Telephone: 905-883-1212/905-883-4554 Ext. 3280 **Fax: 905-883-0772** **OP** ☐

Referring Physician	**Patient Information**
Name:	Name:
Telephone Number:	Date of Birth: (dd/mm/yyyy)
Contact Person:	Primary Number: ☐ Cell ☐ Home ☐ Work:
	Secondary Number: ☐ Cell ☐ Home ☐ Work:
	Mackenzie Health Medical Record Number:

BIOPSY ☐ **ANGIOGRAPHY** ☐ **INTERVENTIONAL** ☐

Abdominal/Pelvis ☐
Kidney ☐
Liver ☐
Lung ☐
Lymph Nodes ☐

Test Required: _____

State reason for request: _____
_____
_____

Cytology Required? Yes ☐ No ☐ **Culture Required?** Yes ☐ No ☐
Imaging Work-up: Has relevant imaging of the area to Bx been performed at Mackenzie Health? Yes ☐ No ☐
If no, are outside films available? Yes ☐ No ☐

Blood Work
Date of last blood work: _____* INR, PTT, CBC, Urea, Creatinine required (good for 14 days unless patient is on anti-coagulants)
(dd/mm/yyyy)

Ordering Physician's Signature: _____

Is patient currently prescribed or taking medications for:

Aspirin	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Anticoagulants	Yes ☐ No ☐	Cardiac	Yes ☐ No ☐
Anti-inflammatory drug	Yes ☐ No ☐	Hypertension	Yes ☐ No ☐
Anti-platelet drug	Yes ☐ No ☐		
Cox-2 Inhibitors	Yes ☐ No ☐		

Does Patient Have:

Renal Disease	Yes ☐ No ☐
History of diabetes	Yes ☐ No ☐
History of excessive bleeding	Yes ☐ No ☐
Significant cardio-pulmonary disease	Yes ☐ No ☐

Patients must not take aspirin, anti-coagulants or anti-inflammatory drugs five (5) days prior to biopsy

If yes, please specify: _____

For Radiologist Use Only

Interventional ☐ Ultrasound ☐
CT ☐

_____
Radiologist Signature

Print Form