Alberta Health Services

Image Guided Interventional Procedures Request

- Fax to Diagnostic Imaging; fax numbers listed at http://www.albertahealthservices.ca/diagnosticimaging
- *Urgent/Emergent requests must be discussed by direct consultation with the radiologist*

Preferred Facility

Patient label here or information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
Address (street, city, province, postal code)	
PHN	Daytime Phone
Inpatient location	

Referring Physician (***PRINT*** *first and last name)*	Physician Phone *(required)*	Physician Fax *(required)*	Contact Number for Critical Test Results *(required)*
Signature	Date *(yyyy-Mon-dd)*	Copy to Physician *(first and last)*	Copy to Fax

Exam requested *(indicate specimen required for biopsies/drainages)*

Relevant clinical history/presumptive diagnosis

Clinical question to be answered

Relevant Previous Imaging Studies

Location	Type	Date *(yyyy-Mon-dd)*	Attached copy
			☐ No ☐ Yes

Current Patient Condition

Date of LMP *(yyyy-Mon-dd)*	Height ☐ cm ☐ in	Weight ☐ kg ☐ lbs

Condition	**No**	**Yes**	**If Yes:**
Allergies *(include any reaction to contrast media)*	☐	☐	Specify:
On Anticoagulants	☐	☐	Specify:
Medications *(including ASA, Plavix)*	☐	☐	Specify:
Isolation Precautions	☐	☐	Specify type:
Diabetic	☐	☐	Metformin *(Glucophage)* ☐ No ☐ Yes
Renal Insufficiency	☐	☐	
On Dialysis	☐	☐	Run days:
Mechanical lift/transfer required	☐	☐	

For biopsies and drainages, indicate specific lab or specimen required: *(attach orders)*

☐ Creatinine	☐ Glucose	☐ LDH	☐ Albumin	☐ Bilirubin
☐ Gram Stain	☐ AFB	☐ Fungi	☐ Culture & Sensitivity *(specify antibiotic use)*:	
☐ pH	☐ Cytology	☐ Cell Count	☐ Other *(specify)*:	

Radiologist to Complete ☐ CT ☐ IR Suite ☐ US

Priority
- ☐ 24 hr
- ☐ 1 week
- ☐ Next Available
- ☐ Other *(specify)*:

- ☐ Day Med
- ☐ DIRR
- ☐ OP Radiology
- ☐ GA
- ☐ PAC
- ☐ Inpatient

Bloodwork
- ☐ None
- ☐ Electrolytes
- ☐ LFT's
- ☐ Creatinine
- ☐ CBC
- ☐ Bilirubin
- ☐ PT/INR
- ☐ Other *(specify)*:

Required within
☐ 1 week ☐ 4 weeks

Pre-Care
- ☐ Pre-Op required — Admit ____ hrs prior
- ☐ Admit day of exam; prep required — Admit ____ hrs prior
- ☐ Admit day of exam and GA; prep required — Admit ____ hrs prior

Length of Recovery

☐ N/A ☐ 2 hrs ☐ 4 hrs ☐ ___ hrs

Procedural Protocol

Patient position ☐ supine ☐ prone

Department Use Only Date format: *yyyy-Mon-dd* - Time format: *hh:mm*

Date Received	Time Received	Appointment Date	Appointment Time
More info required ☐ No ☐ Yes *(specify)*:		Day Med booked ☐ No ☐ Yes	