RVH
Royal Victoria Regional Health Centre

INTERVENTIONAL RADIOLOGY REQUEST

Department of Imaging Services
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PROCEDURE

REQUESTING PHYSICIAN SIGNATURE

PATIENT INFORMATION

Name: _____

HRN: _____

PHIN: _____

Date of Birth: _____

Telephone: _____

In-patient : _____ **Out-patient:** _____

CLINICAL HISTORY (must be completed)

Relevant Imaging: ☐ RVH ☐ Other **Specify Hospital:** _____
Patient Anticoagulated? ☐ Yes ☐ No **Specify Drug:** _____
Allergy to Contrast Media? ☐ Yes ☐ No **Specify Allergy:** _____
Renal Dysfunction? ☐ Yes ☐ No
Diabetic on Metformin? ☐ Yes ☐ No

RADIOLOGIST USE

Booking Code: 1 2 3
Surgical Day Care: ☐ Yes ☐ No
Conscious Sedation: ☐ Yes ☐ No
Laboratory Data: ☐ INR ☐ PTT ☐ Platelets ☐ Creatinine
1 2 3 4 Weeks

Additional Instructions:

RADIOLOGY BOOKINGS USE