

## CONSULTATION FOR INTERVENTIONAL RADIOLOGY

**INPATIENT**     Service: \_\_\_\_\_

Floor \_\_\_\_\_ Room # \_\_\_\_\_ ER \_\_\_\_\_

Portable    Stretcher    Wheelchair    Walk    O<sub>2</sub>

Isolation:  No    Yes/type \_\_\_\_\_

Urgency score (circle)    1 - EMERGENCY  
(See Below)                2 - 24 to 48 hours  
                                      3 - Within 5 Days  
                                      4 - Next available OP Booking

**\*\*\*\* If urgency score is 1 or 2 direct consultation with IR is required. Call KGH 4347. If after hours and emergent, an attending staff will need to page the IR on call \*\*\*\***

Procedure requested: \_\_\_\_\_

Indication for procedure: \_\_\_\_\_

Is the patient anticoagulated?    No    Yes

If Yes, is the patient taking:

ASA, Plavix, Coumadin, Heparin, LMW Heparin (*circle*)

Diabetes  No    Yes - If yes, Insulin Dependent  No    Yes

Contrast Reaction:  No    Yes, If yes explain \_\_\_\_\_

Is patient able to give informed consent?     No    Yes

**If No, please provide Power of Attorney (POA) contact information. POA must be available in person or by phone at the time of the procedure for the procedure to occur.**

**OUTPATIENT**   

CR#: \_\_\_\_\_  Female    Male

Surname: \_\_\_\_\_

First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Health Card # \_\_\_\_\_

Ordering Physician Signature: \_\_\_\_\_

Printed Name & First Initial: \_\_\_\_\_

**\*\* MUST BE CONTINUING CARE PHYSICIAN \*\***

Ordering Physician phone/pager #: \_\_\_\_\_

Attending Physician \_\_\_\_\_

Copy Report to: \_\_\_\_\_

(please print name and first initial)

Date requisition complete \_\_\_\_\_

YYYY/MM/DD

**NOTE: SIDE 'A' OF CONSENT IS THE RESPONSIBILITY OF THE ATTENDING SERVICE  
and must accompany this consultation form.**

**Additional Information Requested by Interventional Radiologist :**

PT \_\_\_\_\_ PTT \_\_\_\_\_ INR \_\_\_\_\_ Platelets \_\_\_\_\_ Hb \_\_\_\_\_

Creatinine: \_\_\_\_\_ (µmol/L)    eGFR\*: \_\_\_\_\_ (mL/minute)

IR Coding: \_\_\_\_\_

Signature of Interventional Radiologist: \_\_\_\_\_

**PLEASE WRITE OR PRINT LEGIBLY**

**INCOMPLETE or ILLEGIBLE requisitions will be returned and may DELAY Booking of the Procedure**