KINGSTON GENERAL HOSPITAL

Fax: 613-548-2413
Tel: 613-548-2301
www.kgh.on.ca

CONSULTATION FOR INTERVENTIONAL RADIOLOGY

INPATIENT ☐ Service: _____

Floor _____ Room # _____ ER_____

☐ Portable ☐ Stretcher ☐ Wheelchair ☐ Walk ☐ O_2

Isolation: ☐ No ☐ Yes/type _____

Urgency score (circle) **(See Below)**
1 - EMERGENCY
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** *****

OUTPATIENT ☐

CR#:_____ ☐ Female ☐ Male

Surname: _____

First Name: _____

Date of Birth: _____

Address: _____

Phone #: (H) _____ (W) _____

Health Card # _____

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.

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