UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute | Mount Sinai Hospital Sinai Health System Joseph & Wolf Lebovic Health Complex | WCH WOMEN'S COLLEGE HOSPITAL Healthcare REVOLUTIONIZED

Medical Imaging Vascular and Interventional Radiology

Tel: 416-340-3384 Fax: 416-340-4661

Patient Information

Medical Record No.: ____________ Health Card No.: ____________ Version Code: ____________

Name: ____________ (First Name) ____________ (Last Name) DOB: ______ (day) / ______ (month) / ______ (year) Sex: ☐ M ☐ F

Address: ____________ City: ____________ Prov.: ____________ Postal Code: ____________

Home Tel.: ____________ Cell: ____________ Business Tel.: ____________

Mobility Status: ☐ Walking ☐ Wheelchair ☐ Stretcher ☐ Ambulance

Billing Information: ☐ OHIP ☐ WSIB ☐ Non Resident/Other Claim Number/Insurance No.: ____________
(include attachments if necessary)

BIOPSY ☐
- Abdominal/Pelvis ☐
- Kidney ☐
- Liver ☐
- Lung ☐
- Lymph Nodes ☐
- Thyroid ☐
- Other ☐

ANGIOGRAPHY ☐

INTERVENTIONAL ☐

Procedure Requested: ____________

Cytology Required? Yes ☐ No ☐

Culture Required? Yes ☐ No ☐

☐ Staging ☐ Restaging ☐ Surveillance

Clinical History and Indication ____________

Consent: if the patient is unable to provide consent in English, he/she must be accompanied by an interpreter.

Imaging Work-up: Has relevant imaging of the area been performed at UHN / MSH / WCH Yes ☐ No ☐
If not, outside images must be available prior to booking. Please mail/deliver images to: Medical Imaging Reception Desk, Toronto General Hospital, PMB 1-100, 585 University Avenue, Toronto, Ontario M5G 2N2

Blood Work: Date of last blood work: ____________
INR, PT, PTT, CBC creatinine required within the last 15 days, and must be submitted with this referral.
If patient is on coumadin, a repeat INR is required 24 hours prior to the procedure date.

Is Patient Currently Prescribed Or Taking Medications For:

Aspirin	Yes ☐	No ☐
Anticoagulants	Yes ☐	No ☐
Anti-inflammatory drug	Yes ☐	No ☐
Hypertension	Yes ☐	No ☐

Does Patient Have:

History of Liver Disease	Yes ☐	No ☐
History of Excessive Bleeding	Yes ☐	No ☐
Significant Cardio-Pulmonary Disease	Yes ☐	No ☐
Heparin Induced Thrombocytopenia	Yes ☐	No ☐
Allergies	Yes ☐	No ☐

If yes, please specify: ____________

Referring Provider Information	
Provider's Name:	
Address:	
Phone:	Fax:
Billing No.:	CPSO:

Provider's Signature: ____________ Date: ____________

Form D-2047 (16/03/2022)