Place Patient Label here

Kawartha Diagnostic Imaging
Suite 102, 327 Charlotte Street Peterborough, Ontario, K9J 0B2
Phone: 705-745-9195 Fax: 705-745-9193

Appointment Date:
Appointment Time:

NUCLEAR CARDIOLOGY REQUISITION

PATIENT INFORMATION

Name:		**Age:**	**Gender:**	**Height (inches)**	**Weight (lbs)**
Date of Birth (dd/mm/yy):		**Health Card Number:**			
Address:		**Family Physician:**			
City:	**Postal Code:**	**Copy to:**			
Home Phone:	**Mobile Phone:**	**Patient Pregnant or Breastfeeding?** ☐ No ☐ Yes *(Patient ≤45 years of age requires negative pregnancy test **PRIOR** to booking)*			

URGENCY

☐ Urgent ☐ Next Available ☐ Elective

For internal use only:

☐ IVMC ☐ RAC ☐ HF

TO SCHEDULE AN APPOINTMENT, FAX THE REQUISITION TO 705-745-9193
EXAM CANCELLATIONS ARE REQUIRED 48 HOURS IN ADVANCE

EXAMINATION REQUESTED	PATIENT PREPARATION/INFORMATION (Please read and follow)
☐ **MUGA or Resting RNA**	No preparation
☐ **Myocardial Perfusion Imaging** ☐ **Exercise/Treadmill** ☐ **Dipyridamole (Persantine)** ☐ **Dobutamine**	**2-Part Test Done on the Same Day** • Bring list of current medications • Wear loose clothing and comfortable shoes • **4 Hours** prior to appointment: **NO** food intake, unless diabetic. • **24 Hours** prior to appointment**: NO** a**ny form of Caffeine or Decaffeinated products** includes: tea, all herbal teas, all soft drinks, all energy drinks, all forms of chocolate ,Tylenol 1,2, 3 and Lenoltec • **24 Hours** prior to appointment: **Remove** Nitro Patch • **24 Hours** prior to appointment: **STOP** Cialis, Levitra, Viagra, Theophylline, Dipyridamole (Aggrenox). • **24 Hours** prior to appointment: **NO** Cannabis use in any form. **48 Hours** prior to appointment: **STOP:** ☐ Beta blockers: _____

CLINICAL INFORMATION: (MUST BE PROVIDED)	INDICATION:	PAST CARDIAC HISTORY:
	☐ Typical Angina ☐ Atypical Chest pain ☐ Dyspnea ☐ CHF/Cardiomyopathy	☐ History of MI:_____ year ☐ Previous PCI: _____year ☐ Previous CABG: _____year

Referring Physician:		**Date(dd/mm/yyy):**
Signature:		**Office Phone:**
OHIP Billing #:	**CPSO #:**	**Fax Number:**