WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

NUCLEAR MEDICINE / GENERAL REQUEST - REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure

Patient Information (Please Print)

Name: _____ Date of Birth (D/M/Y): _____ Sex: ❑ M ❑ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact # ( ) _____ Secondary # ( ) _____ Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ❑ Y ❑ N

ATTENTION ORDERING PHYSICIAN:

BMD - PLEASE FAX PREVIOUS BMD REPORTS IF DONE ANYWHERE IN ONTARIO OTHER THAN WINDSOR REGIONAL HOSPITAL OR LEAMINGTON DISTRICT MEMORIAL HOSPITAL

REQUESTED EXAM: _____

_____

_____

CLINICAL INDICATION:

PLEASE ATTACH ALL PERTINENT REPORTS FOR ALL REQUESTS OTHER THAN BMD:
MRI / CT SCAN / ULTRASOUND / NUCLEAR MEDICINE / X-RAY

SPECIAL NEEDS: ❑ Yes ❑ No If YES, please specify: _____

Print Referring Physician:_____ Fax Number:_____

Referring Physician Signature:_____

Physicians who require copy of report: _____

FOR NUCLEAR MEDICINE USE ONLY:

APPOINTMENT 1:

DATE: _____ **TIME:** _____ **CAMPUS:** _____

APPOINTMENT 2:

DATE: _____ **TIME:** _____ **CAMPUS:** _____

APPOINTMENT 3:

DATE: _____ **TIME:** _____ **CAMPUS:** _____