WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

NUCLEAR MEDICINE/MYOCARDIAL PERFUSION STUDY REQUISTION (MIBI) REQUEST FORM ONLY

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

REASON FOR EXAM

❒ CAD ❒ CHEST PAIN ❒ POST MI FOLLOW UP ❒ PRE OP

❒ OTHER _____

TYPE OF STRESS (CHECK ONE)	PROTOCOL
❒ TREADMILL	HOLD BETA BLOCKERS, CALCIUM CHANNEL BLOCKERS AND CORONARY VASODILATORS FOR 48 HOURS PRIOR TO STRESS
❒ DIPYRIDAMOLE (PERSANTINE)	HOLD THEOPHYLLINE CONTAINING MEDS FOR 72 HOURS PRIOR TO STRESS PATIENT TO BE OFF ALL PRODUCTS CONTAINING CAFFEINE 24 HOURS PRIOR TO THEIR STRESS APPOINTMENT

IF A PATIENT'S CONDITION DOES NOT ALLOW THEM TO FOLLOW THE ABOVE PROTOCOL PLEASE SPEAK DIRECTLY TO THE NUCLEAR MEDICINE DEPARTMENT AT (519) 254-5577 EXT 33453

❒ **ATTACH A LEGIBLE LIST OF MEDICATIONS OR PHARMACY RECORD TO THE REFERRAL**.
❒ **ATTACH ANY PREVIOUS REPORTS: TREADMILL / ANGIOGRAM / ANGIOPLASTY / PFT / NUC MED CARDIAC**

SPECIAL NEEDS: ❒ Y ❒ N If YES, please specify: _____

DIABETIC: ❒ Y ❒ N ASTHMATIC: ❒ Y ❒ N CLAUSTROPHOBIC: ❒ Y ❒ N

ALLERGIES: ❒ Y ❒ N If YES, please list: _____

_____

Print Referring Physician_____ Fax Number:_____

Referring Physician Signature: _____

Physicians who require copy of report: _____

APPOINTMENT 1:

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

APPOINTMENT 2:

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