BLUEWATER HEALTH

Department of Diagnostic Imaging
89 Norman Street
Sarnia, ON N7T 6S3
Phone 519 464-4433 Fax 519 383-8536

☐In Pt & floor _____ ☐Out Pt

Patient Name _____

Address _____

_____ Postal Code _____

Phone: Home _____ Work _____

D.O.B. _____ Sex ☐M ☐F
(DD/MM/YYYY)

Nuclear Medicine

Please complete the following patient information.
Incomplete requests will be returned resulting in a delay of this procedure.

Health Card No. _____ VC _____

Cardiac
☐ Wall Motion (MUGA)

Myocardial Perfusion with SPECT & CT
☐ Exercise
☐ Pharmacological

Skeletal

Bone Scan with SPECT & CT
☐ Whole Body
☐ Single Site _____

Respiratory
☐ V/Q Scan with SPECT & CT
☐ Quantitative Lung Scan with SPECT & CT

Gastrointestinal
☐ Gastrointestinal Bleed with SPECT & CT
☐ Meckel's Diverticulum with SPECT & CT
☐ Hepatobiliary (HIDA)
☐ Liver Spleen Scan with SPECT & CT
☐ RBC Liver Scan with SPECT & CT
☐ Salivary Scan
☐ Gastric Emptying Solid

Neoplasm
☐ Sentinel Node Scan with SPECT & CT

Genitourinary
☐ Functional Renogram
☐ Renogram with Diuretic

Endocrine
☐ Thyroid Uptake & Scan
☐ Parathyroid Scan with SPECT & CT

Infection & Inflammation

Gallium Scan with SPECT & CT
☐ Whole Body
☐ Single Site _____

Pertinent History, Clinical and Imaging Findings:

Physician, please **Fax** this request to the Imaging scheduling office at 519 383-8536 for processing.

_____ _____
Ordering Physician Signature (please also print name) **Date** (DD/MM/YYYY)

_____ _____
Family Physician (please print name) **Copy to Physician** (please print name)

For Imaging Department use only G# _____

Appointment Date _____ at _____ hrs Code _____
(DD/MM/YYYY)