





Fax: 613-548-2413 Tel: 613-548-2301

www.KingstonHSC.ca

CONSULTATION FOR INTERVENTIONAL RADIOLOGY

| INPATIENT Service: | | OUTPATIENT |
|--|---|---|
| Floor Room # ER | | CR#: Female |
| ☐ Portable ☐ Stretcher ☐ Wheelchair ☐ Walk ☐ O₂ | | |
| Isolation: No Yes/type | | Surname: |
| is required. Call KGH an attending staff will | 1 - EMERGENCY 2 - 24 to 48 hours 3 - Within 5 Days 4 - Next available OP Booking is 1 or 2 direct consultation with IR 4347. If after hours and emergent, need to page the IR on call ***** | First Name: |
| Indication for procedure | 9: | |
| Is the patient anticoagulated? No Yes If Yes, is the patient taking: ASA, Plavix, Coumadin, Heparin, LMW Heparin (circle) Diabetes No Yes - If yes, Insulin Dependent No Yes Contrast Reaction: No Yes, If yes explain Is patient able to give informed consent? No Yes If No, please provide Power of Attorney (POA) contact information. POA must be available in person or by phone at the time of the procedure for the procedure to occur. | | Ordering Physician Signature: Printed Name & First Initial: ** MUST BE CONTINUING CARE PHYSICIAN** Ordering Physician phone/pager #: Attending Physician Copy Report to: (please print name and first initial) Date requisition complete |
| | | Date requisition complete |
| NOTE: SI | DE 'A' OF CONSENT IS THE RESPON | SIBILITY OF THE ATTENDING SERVICE |
| and must accompany this consultation form. | | |
| Additional Information | n Requested by Interventional Radiolo | ogist : |
| PT PTT INR Platelets Hb | | |
| Creatinine:(µmol/L) eGFR*:(mL/minute) | | |
| IR Coding: | | |
| Signature of Interventional Radiologist: | | |

PLEASE WRITE OR PRINT LEGIBLY

INCOMPLETE or ILLEGIBLE requisitions will be returned and may DELAY Booking of the Procedure