Alberta Health Services

Image Guided Interventional Procedures Request

- ALL fields must be completed in order to process request
- Fax to Diagnostic Imaging; fax numbers listed at *http://www.albertahealthservices.ca/diagnosticimaging*
- Urgent/Emergent requests must be discussed by direct consultation with a radiologist

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Preferred Facility		Inpatient Location	
Patient Phone Number *(Cell # preferred)*		Patient Address	
City	Postal Code	WCB Claim Number	
Ordering Provider Name	Provider ID	Department ID	
Provider Fax	Provider Phone	Contact Number for Critical Test Results	
Provider Address/Location	City	Postal Code	
Locum ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____			
Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last,first and middle)*	Copy to Fax
Requested Procedure *(indicate specimen required for biopsies/drainages)*			
Reason for Exam			
Clinical question to be answered			

Relevant Previous Imaging Studies

Modality	Location	Date *(dd-Mon-yyyy)*	Attached copy ☐ No ☐ Yes

Current Patient Condition

Date of LMP *(dd-Mon-yyyy)* _____ **Weight** _____ ☐ kg ☐ lbs **Height** _____ ☐ cm ☐ in

Condition	No	Yes	If Yes:
Requires Sedation/Anesthesia			☐ Oral Sedation ☐ IV Sedation ☐ Anesthesia
Anticoagulants or Bleeding Disorder			Specify:
Medications *(including ASA, Plavix)*			Specify:
Isolation Precautions			Specify:
Diabetic			Metformin *(Glucophage)* ☐ No ☐ Yes:
Allergies *(include any reaction to contrast media)*			Specify:
Renal Insufficiency			
On Dialysis			Run days:
Mechanical lift/transfer required			

For biopsies and drainages, enter or attach orders for specific labs or specimens

Radiologist to Complete ☐ **CT** ☐ **IR Suite** ☐ **US**

Priority
☐ 24 hr
☐ 1 week
☐ Next Available
☐ Other *(specify):*
_____
_____

☐ Day Med
☐ DIRR
☐ OP Radiology
☐ GA
☐ PAC
☐ Inpatient

Bloodwork
☐ Electrolytes ☐ LFT's
☐ Creatinine ☐ CBC with diff
☐ Bilirubin ☐ INR
☐ None
☐ Other *(specify):* _____
_____
Required within
☐ 1 week ☐ 4 weeks

Pre-Care
☐ Pre-Op required
☐ Admit day of exam; prep required
☐ Admit day of exam and GA; prep required
} Admit ____ hrs prior

Length of Recovery
☐ N/A ☐ 2 hrs ☐ 4 hrs ☐ ____ hrs

Procedural Protocol
Patient position ☐ supine ☐ prone

Department Use Only

Date Received *(dd-Mon-yyyy)*	Time Received *(hh:mm)*	Appointment Date *(dd-Mon-yyyy)*	Appointment Time *(hh:mm)*

More info required ☐ No ☐ Yes *(specify):* _____ Day Med booked ☐ No ☐ Yes