

Charlton Campus    King Campus    West 5<sup>th</sup> Campus

## INTERVENTIONAL RADIOLOGY OUTPATIENT ORDER

FAX: 905-540-6576   TEL: 905-522-1155 ext. 35387

PLACE PATIENT ID  
LABEL HERE

<p><b>Date:</b> <input style="width: 100px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/></p> <p style="text-align: center; font-size: small;">yyyy                      mm                      dd</p> <p><b>Priority:</b>    <input type="checkbox"/> Routine                      <input type="checkbox"/> Urgent  <input type="checkbox"/> Ultrasound Guided   <input type="checkbox"/> CT Guided   <input type="checkbox"/> Angio</p> <p><b>Exam Requested (Specify):</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Clinical Information/Relevant History:</b>  <i>Include specific question to be answered</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Discussed with Radiologist:</b> <input type="checkbox"/> Yes</p> <p><b>Name of Radiologist:</b> _____</p> <p><b>Relevant tests already performed:</b></p> <p><input type="checkbox"/> CT   <input type="checkbox"/> Ultrasound   <input type="checkbox"/> Xray   <input type="checkbox"/> Angio   <input type="checkbox"/> MRI</p> <p><input type="checkbox"/> Nuc Med   <input type="checkbox"/> Other/Location: _____</p>	<table border="1" style="width:100%; 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**INCOMPLETE FORMS WILL BE RETURNED**