BRANT COMMUNITY HEALTHCARE SYSTEM

NUCLEAR MEDICINE REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9

Tel: 519-751-5599 Fax: 519-751-5582

For Office Use Only:
Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		**PATIENT INFORMATION**	
Name:		Health Card / Version / DOB (D D M M Y Y Y Y) / Sex (M F U)	
OHIP Billing Number:		First Name:	Last Name:
Address		Address:	
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:		WSIB Claim #:	Secondary Insurance:
Copies to:		Patient Height:	Patient Weight:

Does Patient Require Assistance? Mechanical Lift ☐Y ☐N Wheelchair ☐Y ☐N Language Interpreter ☐Y ☐N

Specify: _____

Is the patient: Diabetic ☐Y ☐N Pregnant/Breastfeeding ☐Y ☐N Special Needs/Impairment ☐Y ☐N

Specify: _____

EXAM REQUESTED (BY APPOINTMENT ONLY) **INCOMPLETE REQUISITIONS WILL BE RETURNED**

If urgent please provide physician call back number for results:

CURRENT MEDICATIONS: (or attach list)

CLINICAL HISTORY: REASON FOR ORDER

Related Previous Imaging: ☐ Yes ☐ No If yes, Where: Please attach previous if not completed at BGH.

For Nuclear Medicine Use Only:

Please include all relevant patient history including previous reports or consult notes as appropriate.

Date Request Submitted: _____