St. Joseph's Hospital
Diagnostic Imaging Centre, Room Co-200
268 Grosvenor St., PO Box 5777, Stn. B
London, ON N6A 4V2
Tel. 519-646-6044

INTERVENTIONAL RADIOLOGY REFERRAL FORM

Fax to 519-646-6204

1. Patient Information

Label / Addressograph:

Last name: _____ First Name: _____

Date of birth: _____ (YYYY/MM/DD) Gender: M F

Address: _____
Street Address City Postal Code

Phone: _____ Alternate Phone: _____

Health card number: _____ Version Code: _____

Preferred language ☐ English ☐ Other: _____
Interpreter required? ☐ No ☐ Yes

Mobility ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Portable ☐ Mechanical lift required

Diabetes ☐ No ☐ Yes **Pregnant** ☐ No ☐ Unknown ☐ Yes, _____ weeks

2. Allergies: ☐ None ☐ If patient has known latex or contrast allergy, please notify us as soon as possible at 519-646-6044

3. Previous exams ☐ None

☐ X-Ray	**at**	☐ St. Joseph's Health Care London	☐ LHSC	☐ Other:	_____
☐ Nuc Med	**at**	☐ St. Joseph's Health Care London	☐ LHSC	☐ Other:	_____
☐ Ultrasound	**at**	☐ St. Joseph's Health Care London	☐ LHSC	☐ Other:	_____

4. Exam requested:

☐ **Other**: _____

☐ **Port-a-Cath Insertion or Removal** → Interval between chemo treatments: _____

→ Last chemo date: _____ (YYYY/MM/DD) → Next chemo date: _____ (YYYY/MM/DD)

Diagnosis suspected: _____

Clinical Findings and History:

5. Referring Health Care Provider

Last name: _____ First Name: _____ **Signature**: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Fax: _____ OHIP Billing Number: _____

Copy to (Name / Fax): _____

Radiology Dept use only: ☐ Emergency ☐ Urgent ☐ Elective ☐ Research Appointment date: _____

Revised: Nov. 2019