St. Joseph's Hospital
Diagnostic Imaging Centre, Room C0-200
268 Grosvenor St., PO Box 5777, Stn. B
London, ON N6A 4V2
Tel. 519-646-6044

ST JOSEPH's HEALTH CARE LONDON

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: ______________

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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: ______________