WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

GASTRIC / SPECIAL PROCEDURES REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure

Patient Information (Please Print)

Name: _____ Date of Birth (D/M/Y): _____ Sex: ☐ M ☐ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact # ( ) _____ Secondary # ( ) _____Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ☐ Y ☐ N

CLINICAL INFORMATION:

G.I. EXAMS

- ☐ U.G.I
- ☐ U.G.I & Small Bowel Only
- ☐ Small Bowel Only
- ☐ Barium Swallow - Esophagus
- ☐ Gastrografin Enema
- ☐ Barium Enema

Other: _____

SPECIAL PROCEDURES (PLEASE CHECK IF APPLICABLE)

- ☐ Implanted Venous Access Port
  - ☐ Single ☐ Double ☐ Triple
- ☐ PICC Line
  - 1st dose IV required? ☐ Y ☐ N
  - Specify medication _____
- ☐ G-Tube Insertion
- ☐ G-Tube Re-Insertion
- ☐ G-Tube Check
- ☐ G-J Tube Insertion
- ☐ G-J Tube Re-Insertion
- ☐ G-J Tube Check
- ☐ Nephrostomy Tube
- ☐ Chest Fluoro
- ☐ Other: _____
- ☐ Loopogram
- ☐ Nephrostogram
- ☐ Siaglogram: Indicate duct and side _____
- ☐ Sinogram / Fistulogram: (location)_____
- ☐ Urethrogram
- ☐ Arthrogram ☐ R ☐ L
- ☐ Myelogram Specify Level: _____
- ☐ Cystogram
  - *Is patient catheterized*? ☐ Y ☐ N
- ☐ Voiding Cystogram
  - *Is patient catheterized*? ☐ Y ☐ N
- ☐ Facet Injections ☐ R ☐ L ☐ BIL
  - Specify Levels: _____
- ☐ Shoulder Injection ☐ R ☐ L
- ☐ Hip Injection ☐ R ☐ L
- ☐ Epidural Injection
- ☐ Rhizotomy
- ☐ Nerve Block

Allergies to contrast (dye) ☐ Y ☐ N

Can patient sign consent form? ☐ Y ☐ N

Patient taking Anticoagulants ☐ Y ☐ N

Why: Cardiac, DVT, Other _____

Print Referring Physician_____ Fax Number:_____

Referring Physician Signature:_____

Physicians who require copy of report:_____

APPOINTMENT:

DATE: _____ **TIME:** _____ **CAMPUS:** _____