

**NUCLEAR MEDICINE/MYOCARDIAL PERFUSION STUDY  
REQUISITION(MIBI) REQUEST FORM ONLY**

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 (MM/DD/YYYY): \_\_\_\_\_ 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

**REASON FOR EXAM**

- CAD  CHEST PAIN  POST MI FOLLOW UP  PRE OP  
 OTHER \_\_\_\_\_

TYPE OF STRESS (CHECK ONE)	PROTOCOL
<input type="checkbox"/> TREADMILL	HOLD BETA BLOCKERS, CALCIUM CHANNEL BLOCKERS AND CORONARY VASODILATORS FOR 48 HOURS PRIOR TO STRESS
<input type="checkbox"/> DIPYRIDAMOLE (PERSANTINE)	HOLD THEOPHYLLINE CONTAINING MEDS FOR 72 HOURS PRIOR TO STRESS  PATIENT TO BE OFF ALL PRODUCTS CONTAINING CAFFEINE 24 HOURS PRIOR TO THEIR STRESS APPOINTMENT

IF A PATIENT'S CONDITION DOES NOT ALLOW THEM TO FOLLOW THE ABOVE PROTOCOL PLEASE SPEAK DIRECTLY TO THE NUCLEAR MEDICINE DEPARTMENT AT (519) 254-5577 EXT 33453

- ATTACH A LEGIBLE LIST OF MEDICATIONS OR PHARMACY RECORD TO THE REFERRAL.  
 ATTACH ANY PREVIOUS REPORTS: TREADMILL / ANGIOGRAM / ANGIOPLASTY / PFT / NUC MED CARDIAC

SPECIAL NEEDS:  Y  N If YES, please specify: \_\_\_\_\_  
 DIABETIC:  Y  N ASTHMATIC:  Y  N CLAUSTROPHOBIC:  Y  N  
 ALLERGIES:  Y  N If YES, please list: \_\_\_\_\_

Print Referring Physician \_\_\_\_\_ Fax Number: \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_

Physicians who require copy of report: \_\_\_\_\_

**APPOINTMENT 1:**  
 DATE (MM/DD/YYYY): \_\_\_\_\_ TIME: \_\_\_\_\_ CAMPUS: \_\_\_\_\_

**APPOINTMENT 2:**  
 DATE (MM/DD/YYYY): \_\_\_\_\_ TIME: \_\_\_\_\_ CAMPUS: \_\_\_\_\_