



Centre intégré
universitaire de santé
et de services sociaux
du Centre-Ouest-
de-l'Île-de-Montréal
Québec

Hôpital général juif
Jewish General Hospital

Nuclear Medicine

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Patient name / Hospital card stamp / Clinic sticker

Nuclear Medicine Requisition

PATIENT INFORMATION

Location? ☐ Outpatient ☐ Inpatient room: _____

Pregnant or breastfeeding? ☐ No ☐ Yes

Claustrophobic? ☐ No ☐ Yes

TELEPHONE _____

CELLULAR _____

EMAIL _____

BARCODE SPACE
DO NOT WRITE HERE

Cardiovascular

- ☐ MUGA (LVEF)
- ☐ Myocardial perfusion scan
 - ☐ Dipyridamole (Persantine)
 - ☐ Exercise
 - ☐ Hold meds: _____
- ☐ Cardiac amyloid scan (PyP)
- ☐ First pass study (RVEF or L-R shunt)
- ☐ R-L shunt (MAA)

Endocrine

- ☐ Thyroid uptake & scan
- ☐ Thyroid scan only (no uptake)
- ☐ Iodine-131 whole body scan (4 mCi)
 - ☐ Thyrogen stimulated
 - ☐ Thyroid hormone withdrawal
- ☐ Parathyroid scan

Pulmonary

- ☐ V/Q lung scan
- ☐ Quantitative Q scan

Radionuclide Therapy

- ☐ Iodine-131 for cancer + WB scan
Dose: _____ mCi
 - ☐ Thyrogen stimulated
 - ☐ Thyroid hormone withdrawal
- ☐ Iodine-131 for hyperthyroidism

Gastrointestinal

- ☐ Liquid gastric emptying
- ☐ Solid gastric emptying
- ☐ Hepatobiliary scan (HIDA)
- ☐ Hepatobiliary scan + CCK
- ☐ Gastroesophageal reflux
- ☐ Aspiration study
- ☐ Esophageal transit
- ☐ Lower GI bleed scan
- ☐ Salivary gland scan
- ☐ Hemangioma scan (Liver)
- ☐ Liver & spleen scan
- ☐ Meckel's scan
- ☐ Denatured RBC scan

Oncologic

- ☐ Sentinel lymph node mapping
- ☐ Iodine-125 seed
 - ☐ Breast Qty: _____
 - ☐ Axilla Qty: _____

Urologic

- ☐ Renal scan
- ☐ Renal scan + Lasix
- ☐ Renal scan + Captopril

Musculoskeletal

- ☐ Bone scan, whole body
- ☐ Bone scan, site: _____
- ☐ Joint scan, whole body
- ☐ Bone scan + FDG PET (Osteomyelitis)
Site: _____

Other

- ☐ Peritoneal leak study
- ☐ _____
(Whole body PET requires different requisition)

Please indicate your *specific clinical question*, including relevant past medical history:

REFERRER INFORMATION (ATTENTION RESIDENTS AND FELLOWS: SUPERVISING STAFF NAME MUST APPEAR BELOW.)

STAFF NAME (PRINT) _____

SIGNATURE _____

LICENSE NUMBER _____

DATE _____

TELEPHONE _____

EMAIL _____

CC _____

Staff name is required. Provide prior relevant non-DSQ imaging on digital media & pathology reports. Patient preparation may be required, contact us.