SickKids®

THE HOSPITAL FOR
SICK CHILDREN

Request for Image Guided Therapy (IGT)

IGT Booking: Telephone (416) 813 – 6054; Fax (416) 813 – 2139
Department of Diagnostic Imaging (Atrium 2nd floor)

APPOINTMENT DATE: ____________________

Name:
Sex: M F
HSC#
OHIP health card #
Date of birth:
Address:
City: Province:
Postal code:
Parent/guardian: ______________________________
Telephone: ______________________________
Registration #

ADDRESSOGRAPH

Referring Physician

Physician name: ______________________________
Address: ______________________________

Department at HSC: ______________________________
Telephone #: ____________________ Fax #: ________________
Pager number: ____________________

1. Interventional procedure requested:
   a)
   b)
   c)

2. Additional procedures required at time? ❑ Yes ❑ No
If yes, specify and list contact person with pager #:

3. Endocarditis prophylaxis required? ❑ Yes ❑ No
4. Pathology required? ❑ Yes ❑ No
5. PICU bed required? ❑ Yes ❑ No
6. Is the patient on anticoagulants? ❑ Yes ❑ No

If yes, please specify: ______________________________

7. Reason for procedure (signs, symptoms, clinical findings)

Patient: weight: ____________kg Height: ___________ cm

8. Sedation / general anesthetic (GA)

a) Will this patient require ❑ **Sedation** or ❑ **GA** for this procedure? (See reverse for guidelines to consider.)
b) Please indicate why (check one):
❑ Child may be uncooperative (age or behaviour related)
❑ Altered mental status (development delay, bipolar, etc.)
❑ Pain control or nature of procedure required
❑ Other (list) ______________________________

If sedation required, please complete DI Sedation/GA Screening Form

9. Working or known diagnosis

10. Previous relevant studies? Please list type and date.

Type	Date
______________________________	____________
______________________________	____________
______________________________	____________

11. Additional relevant history / comments (allergies, previous reaction to contrast, special positioning, isolation, etc.)

12. Preferred date of procedure/urgency:

13. Requested by:

Signature: ________________________ Print name: ___________________________ Date ____________ Time __________

If requesting physician is not an attending, provide **HSC STAFF Name**: ______________________________

Consent will be obtained by an IGT physician

Exam results (images and report) will be available through PACS or PACS Web

Request for Image Guided Therapy (IGT)

Diagnostic Imaging - IGT Booking/Consult Procedure

1. Procedures will be requested by a Physician or under an HSC Medical Directive. If the requester is not the attending physician, the HSC staff physician name has to be included with the request. An HSC staff has also to be identified as the responsible physician.
2. Procedures will be booked upon receipt of a signed 'Request for IGT' form. Discussion with Radiologist regarding the procedure may be required. All required information has to be included, or the form(s) will be returned to you for completion, resulting in a delay in booking the procedure. In addition to the Request form, the DI Sedation/GA Screening Form has to be completed and sent if sedation/general anesthesia is required for any DI study/procedure.
3. If the request is Emergent (within 24 hours), please call the department to consult with the Radiologist. We will still need the Request form prior to granting an appointment.

General guidelines for sedation or general anesthetic in Diagnostic Imaging as they apply to IGT

Sedation versus General Anesthetic – as per the HSC Sedation Guidelines.

To follow are the basic criteria a patient must meet to be considered for sedation. For more detailed information please refer to HSC Sedation Guidelines.

General criteria for sedation:

- ASA classification of I or II
- NPO guidelines followed
- Normal cardiovascular status
- Normal respiratory/airway status

If you have any questions regarding possible need for sedation or general anesthetic please contact the IGT department as appropriate at (416) 813-6054.

DI USE ONLY Priority	Imaging Required:	Booking
❑ Emergency (within 24 hours) ❑ High priority (within ____ days) ❑ Elective (next avail. appointment) Allotted time ________________ Approved by: __________________	❑ US ❑ Fluoro C-Arm ❑ Fluoro CT ❑ Other __________________ **Fasting Status**: ____________	Date received: y _______ m _______ d _______ Appt. Date & Time: y _______ m _______ d _______ Time of Appt.: ______ Time to arrive in Dept. ________ Referring MD notified: y _______ m _______ d ______ Family notified: y _______ m _______ d _______

For IGT use ONLY

DATE: TIME:

PROCEDURE:

Patient pregnant? Yes or No

RADIOLOGIST:

MRT:

RN:

FLUORO:

DEVICE: