UCLA Nuclear Medicine Services

Nuclear Medicine Consultation Request and Order

UCLA Medical Center/UCLA Medical Plaza

Patient Name & Medical Record Number or
Patient Labels Required

PLEASE PRINT CLEARLY – Physicians complete gray shaded areas

Clinic/Unit **(Required)**	Date/Time Requested **(Required)**	Female: Pregnant? **(Required)** ☐ No ☐ Yes
Primary Diagnosis **(Required)**	Weight **(Required)** **lb / kg**	Height **(Required)** **in / cm**

Procedure Requested (**Required**)

Transport without: (N/A for ICU pts, see page 3) ☐ Cardiac Monitor ☐ Pulse Oximetry

Complete for Cardiac Stress Test ONLY ☐ Asthmatic ☐ On Inhalers ☐ Diabetic Caffeine in last 6 hrs? ☐ Yes ☐ No **Hold caffeine 24 hrs prior to test**

Clinical History Pertinent To Nuclear Med Procedure **(Required)**

Precautions/Allergies **(Required)**
(Diabetes, pertinent medications)

Requesting Physician Signature **(Required)**	Print Requesting Physician Name **(Required)**	Requesting Physician ID/Beeper# **(Required)**	Print Attending Physician Name **(Required)**

Inpatient Nursing (Completion Required) **Last time patient ate: _____ a.m. / p.m.** **Special Care Needs:** ☐ None of the following

☐ Isolation Type:_____ ☐ Restraints ☐ Epidural ☐ Flolan ☐ Insulin drip ☐ PCA ☐ continuous IV med. for BP/HR/sedation

Transport Plan: ☐ Oxygen ☐ Cardiac Monitor ☐ Ventilator ☐ Transport Nurse ☐ 1:1 ☐ Bed ☐ Gurney ☐ Wheelchair ☐ Ambulatory

COMPLETE ALL ABOVE PRIOR TO FAXING ☐ **Phone Verification Fax Received by Nuc Med**	Unit Secretary Signature **(Required)** Date/Time	RN Signature **(Required)** Date/Time

NUCLEAR MEDICINE NOTES AND PRESCRIPTION