Nuclear Medicine Department
I-131 Therapy
Requisition/Communication

St. Joseph's Healthcare Hamilton

Patient ID

Booking Fax: (905) 521-6018 **NM Department:** (905) 521-6095

I-131 Therapy for: ❒ Benign Condition [Grave's, Toxic nodule(s)] **OR** ❒ Thyroid Cancer [❒ Inpatient ❒ Outpatient]

Requested I-131 Dose: _____ MBq mCi (circle one) **OR** ❒ Dose to be prescribed by NM Physician

Benign Thyroid Disease

Clinical Diagnosis: _____

❒ NM Thyroid Scan & RAIU Completed Date: _____ (YY/MM/DD) Location: _____

OR

❒ NM Thyroid Scan & RAIU To Be Performed Prior to Possible Treatment ❒ MUMC ❒ SJHH

Blood work: **Date:** _____ (YY/MM/DD)

❒ TSH _____ mU/L

❒ Free T4 _____ pmol/L

❒ Free T3 _____ pmol/L

Medications (Please list all): _____

_____

_____

Note: We will stop anti-thyroid medication 5 days prior to scan &/or RAIU/Therapy and restart 3 days post-procedure(s) *unless you indicate otherwise below*:

_____

_____

Thyroid Cancer Therapy and Post Therapy Scan

Thyrogen™ To Be Used? ❒ Yes ❒ No ❒ Awaiting Insurance Approval

Thyrogen™ Administration: ❒ My Office ❒ Family MD Office ❒ Infusion Centre

Note: If Thyrogen™ is not be used, thyroid hormone suppression therapy will be as follows *unless you indicate otherwise below*: LT4 will be stopped 4 weeks prior to planned therapy date, and treatment with LT3 substituted for 2 weeks. The patient will not receive any thyroid hormone for 2 weeks prior to therapy. TSH will be measured and confirmed to be > 30 mU/L 5 days prior to planned treatment. LT4 will be restarted 3 days post-therapy.

Alternate Instructions: _____

_____

_____

Please attach the following:

❒ Operative Report(s)

❒ Pathology Report(s)

❒ Current Medication List

❒ Completed I-131 Therapy Patient Screening Questionnaire

Referring Physician:_____ (PRINT) Signature: _____ Date: _____ (YY/MM/DD)

PLEASE REMEMBER TO PROVIDE THE PATIENT WITH THE APPROPRIATE INFORMATION BOOKLET