SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Imaging - FAX: 905-830-5966

Health Record #: ____________ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* ____________
DOB: mm / dd / yy Age: ______ ❑ Female ❑ Male
OHIP #: ____________ Version Code: ____________
Phone #: ____________

CT Requisition

Patient Preparation and Information on reverse side

❑ OUT-PATIENT ❑ IN-PATIENT ❑ ED PATIENT ❑ ED CALLBACK

Patient Name:		**Appointment Date:** mm / dd / yy
Address: Street Number + Name	Apartment	**Appointment Time:**
City Province	Postal Code	**Arrival Time:**
Health Card Number:	**Version Code:**	**Hospital Record #:**
Other Insurance:	**WSIB Number:**	**Date of Birth:** mm / dd / yy
Home: ( )	**Work/Other:** ( )	**Patient Weight:**

Patient not available: From: mm / dd / yy To: mm / dd / yy
Reason:

Area to be scanned:

Clinical Question:

Relevant Clinical Information:

RENAL FUNCTION ASSESSMENT
(please check (✓) appropriate)

❑ Hx of Renal Disease ❑ Stroke
❑ On Dialysis ❑ Hypertension
❑ Diabetes ❑ Over 70 yrs of age
❑ Chemotherapy ❑ Gout
❑ Vascular Disease ❑ Cirrhosis

If **YES** to any of the above we require a current creatinine/eGFR (in the last 3 months): attached to the requisition.

❑ The patient has **NONE** of the above risk factors.

Venous Access in situ: ❑ Port ❑ PICC

Allergy to contrast ❑

Referring Physician:	**Address:**
Signature:	**Office Phone:** ( )

RADIOLOGIST USE ONLY

Head	❑ Without Contrast	❑ With Contrast
Neck	❑ Without Contrast	❑ With Contrast
Thorax	❑ Without Contrast	❑ With Contrast
Abdomen	❑ Without Contrast	❑ With Contrast
Pelvis	❑ Without Contrast	❑ With Contrast
Triphasic Liver	❑ Without Pelvis	❑ With Pelvis
Renal Mass	❑ Without Pelvis	❑ With Pelvis
Pancreas	❑ Without Pelvis	❑ With Pelvis
Facial Bones	❑ Without Mandible	❑ With Mandible
Spine	❑ C-spine	❑ L3 to S1
	❑ Other ____________	
High Res Chest	❑ Inspiration ❑ Bronchiectasis	❑ Interstitial
Thorax	❑ Aneurysm	❑ Dissection
Abdomen	❑ Aneurysm	❑ Dissection
Pelvis	❑ Aneurysm	❑ Dissection
❑ **Sinuses**	❑ **Wrist**	❑ **Pulmonary Angio**
❑ **Renal Colic**	❑ **Hip**	❑ **Carotid Angio**
❑ **Urogram**	❑ **Ankle/Foot**	❑ **Circle of Willis**

Protocol Notes:

RADIOLOGIST USE ONLY:
Priority: *(please circle)*
1 2 3 4

Is this a specified date (timed) procedure?
If yes, specify date: ____________

Clinical Indications for Scan:
❑ Cancer Staging and/or Diagnosis
❑ Breast Cancer Screening
❑ Other Diagnosis

Radiologist/MRT (R):

Radiologist/MRT (R) Signature:

The collecting of personal information on this form is done in accordance with Southlake's Privacy Policy. Details are available on our website, www.southlakeregional.org

SL0260_20 (07/13) "Diagnostic Imaging" Review (07/16)

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Diagnostic Imaging

Patient Preparation and Information

PATIENT PREPARATIONS:

Please follow instructions listed below the appropriate test.

CT Abdomen and/or Pelvis:	CT Chest:	CT Head or Spine or Neck:
• Nothing to eat or drink for 2 hours prior to **appointment time**. • You may be asked to drink a clear fluid. This will help to create an outline of your digestive system. Please note that it could take up to 2 hours for the fluid to work its way through your entire digestive system.	• You may eat or drink and take medication(s) as usual. • Please bring most recent chest x-ray(s), if not done at Southlake. • You may be asked to have another chest x-ray today.	• You may eat or drink and take medication(s) as usual.

PLEASE NOTE:

- **Bring this requisition and your Ontario Health card.**
- You can pre-register for your appointment before arriving at the Hospital, online at www.southlakeregional.org or by calling 905-895-4521, ext. 2868.
- Upon arrival you are required to check-in for your appointment at one of our Welcome Centres or Self-Serve Kiosks before proceeding to Diagnostic Imaging Reception.
- If you are unable to keep your appointment, please call Patient Scheduling at 905-895-4521, ext. 2665.

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