

# Request for CT Consultation

(Computed Tomography)

**HNHB LHIN**

Last Name		First Name	
HIN/HCN/OHCN/OHIP #		Date of Birth (yyyy/mm/dd)	
Address			
City / Province		Postal Code	
Phone Number:		Mobile Number:	
Gender	Weight (kg)	Age	

REQUEST TO: \_\_\_\_\_ Referral Date: \_\_\_\_\_

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>Brantford General Hospital</b><br>Phone: 519-751-5545<br>Fax: 519-752-9983                                       | <input type="checkbox"/> <b>Greater Niagara General</b><br>Phone: 905-378-4647<br>Fax: 905-358-7438   | <input type="checkbox"/> <b>Haldimand War Memorial Hospital (Dunnville)</b><br>Phone: 905-774-7431<br>Ext: 1221<br>Fax: 905-774-7914 |
| <input type="checkbox"/> <b>Hamilton General Hospital</b><br>Phone: 905-521-2100<br>Ext: 49600<br>Fax: 905-527-9053                          | <input type="checkbox"/> <b>Joseph Brant Hospital</b><br>Phone: 905-336-4126<br>Fax: 905-336-4148   |  |
| <input type="checkbox"/> <b>Juravinski Hospital &amp; Cancer Centre (Hamilton)</b><br>Phone: 905-389-4411<br>Ext: 41484<br>Fax: 905-387-8813 | <input type="checkbox"/> <b>McMaster University Medical Centre &amp; Children's Hospital (Hamilton)</b><br>Phone: 905-521-2100<br>Ext: 41484<br>Fax: 905-521-5086 | <input type="checkbox"/> <b>Norfolk General Hospital</b><br>Phone: 519-426-0130<br>Ext: 2219<br>Fax: 519-429-6892                    |
|  | <input type="checkbox"/> <b>St. Catharines Hospital</b><br>Phone: 905-378-4647<br>Fax: 905-684-6990   | <input type="checkbox"/> <b>St. Joseph's Healthcare (Hamilton)</b><br>Phone: 905-522-1155<br>Ext: 35278<br>Fax: 905-521-6166         |
|  |   | <input type="checkbox"/> <b>Welland Hospital</b><br>Phone: 905-378-4647<br>Fax: 905-732-9537   |

Referring Physician: \_\_\_\_\_ Unit: \_\_\_\_\_ Phone: \_\_\_\_\_  
Printed Name Signature & Designation

Hospital/Other Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Send Additional Report to:  Primary Care Physician  Other: \_\_\_\_\_  
Printed Name Phone Number Fax

Exam Payee:  
 OHIP  WSIB #  Self  Third Party  
Specify: \_\_\_\_\_

Patient Routing:  
 Hospital preference: \_\_\_\_\_  
 Next available appointment at any hospital

Exam Requested (be specific):

Current Patient Location:  
 Inpatient  Outpatient  Emergency

Language Preferred:  English  French  Other: \_\_\_\_\_  
Interpreter Required?  Yes  No

Clinical Information / Relevant History:

**Please answer all of the following questions:**

1) Known Renal Disease? **YES / NO**  
2) Known Diabetes? **YES / NO**  
3) On Metformin? **YES / NO**

If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:

eGFR: \_\_\_\_\_ ml/min/1.73<sup>2</sup> Date (yyyy/mm/dd): \_\_\_\_\_  
Creatinine: \_\_\_\_\_ ml/min/1.73 Date (yyyy/mm/dd): \_\_\_\_\_

4) **Known Contrast Allergy?**  
If **yes**, has the patient been provided with the pre-medication instructions listed below:  
 Prednisone **50 mg** PO 12 hours and 2 hours pre-procedure  
 Diphenhydramine **50 mg** PO/IV 1 hour pre-procedure

Relevant tests to date:

Study (e.g. CT/MRI/Xray)	Date (yyyy/mm/dd)	Location

If this is a follow-up exam, please indicate requested date:  
\_\_\_\_\_ (yyyy/mm/dd)

**FOR CT USE ONLY**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name Signature & Designation (yyyy/mm/dd)

Priority: **1 2 T2 3 T3 4 T4** Test Date: \_\_\_\_\_ Test Time: \_\_\_\_\_  
(yyyy/mm/dd) (hh:mm)

Clinical Indication:  Cancer  Other: \_\_\_\_\_

Protocol: \_\_\_\_\_ Radiologist (printed): \_\_\_\_\_  
Date Protocolled: (yyyy/mm/dd)

Additional Comments: \_\_\_\_\_ Signature: \_\_\_\_\_