

Request for CT Examination

(By Appointment Only)

PATIENT INFORMATION			MRN N^o	APPOINTMENT DATE:			TIME:	
IN-PATIENT	OUT-PATIENT	ER					ARRIVAL TIME:	
Last Name				First Name				
Date of Birth (d/m/y)			M	F	Health Card N ^o	WSIB N ^o	3rd Party Ins. N ^o	
Address								
City		Postal Code	Contact Number			OK to leave voice mail message		

Examination

HEAD	EXTREMITY: _____
NECK	VIRTUAL COLONOSCOPY
C-SPINE	ENTEROGRAPHY
CHEST	STROKE
ABDOMEN	SPINE: LEVEL _____
PELVIS	OTHER _____

RELEVANT CLINICAL HISTORY:**IF THIS SECTION IS NOT COMPLETE, REQUISITION WILL BE RETURNED TO THE ATTENDING PHYSICIAN.**

- IS THE PATIENT ABLE TO GIVE CONSENT? YES NO If NO, please provide signed consent form.
- ARE THERE ANY CONTRAINDICATIONS TO IV CONTRAST? (i.e. allergy, Metformin, renal/heart disease)

3. (a) RENAL FUNCTION ASSESSMENT (please check appropriate box)

Hx of Renal Disease	Chemotherapy	Hypertension	Cirrhosis	On Dialysis
Vascular Disease	Over 70 years	Stroke	Gout	Diabetes

(b) If YES to any of the above, we require a current creatinine/eGFR in the last 6 months.

CREATININE LEVEL: CR _____ **eGFR** _____ **DATE:** _____

Patient has NONE of the risk factors

FOR DEPARTMENT USE ONLY				
EXAMINATION/ SPECIAL INSTRUCTIONS:	PRIORITY: P1 P2 P3 P4			
	Radiologist Signature:			

PHYSICIAN INFORMATION

Physician's Name (Please PRINT clearly)		OFFICE STAMP:
Address/ Phone	CPSO#	
Physician's Signature X		

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.