



200 Fletcher Crescent
Alliston, Ontario L9R 1W7

FOR BOOKINGS ONLY: Phone: 705-434-5133 Fax: 705-434-5111

Patient Notified LVM Date: _____

Appt. Date/Time: _____ Prep. Explained

Notes: _____

COMPUTED TOMOGRAPHY (CT) REQUISITION - FOR EMERGENCY AND INPATIENTS

Patient Name:		
DOB: (dd/mm/yyyy)		
OHIP #:	VC:	MR #:

PATIENT LABEL

SCREENING REQUIREMENTS FOR PATIENTS RECEIVING IODINATED CONTRAST	YES	NO
1. Can the patient provide consent? If no, please specify _____		
2. Is the patient 60 years of age or older?		
3. Has the patient had a previous allergic reaction to contrast?		
4. Does the patient have a history of renal disease, including: known chronic kidney disease (CKD), remote history of AKI, dialysis, kidney surgery, kidney ablation, Albuminuria		
5. Does the patient have a history of diabetes mellitus?		
6. If applicable, could the patient be pregnant?		
7. Required for YES answers to questions 2 through 5. Date: (dd/mm/yyyy) _____ Creatinine level _____ $\mu\text{mol/L}$ Patient weight _____ kg OR eGFR _____ mL/min/1.73 m ² <small>(ED patient: within 24 hrs or less. Inpatient: within 48 hrs or less) (Required if creatinine level > 130 $\mu\text{mol/L}$)</small> GFR _____ mL/min/1.73 m ²		

AREA TO BE SCANNED: (check box)

- | | | | | |
|---|---|----------------------------------|---|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Sinuses | <input type="checkbox"/> C-Spine | <input type="checkbox"/> Thorax | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Facial Bones | <input type="checkbox"/> Mastoids/Temporal Bones | <input type="checkbox"/> T-Spine | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Renal Stone Protocol |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Code Stroke EVT | <input type="checkbox"/> L-Spine | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Extremity |
| <input type="checkbox"/> CTA _____
<small>(please specify)</small> | <input type="checkbox"/> Other _____
<small>(please specify)</small> | | <input type="checkbox"/> R or <input type="checkbox"/> L _____
<small>(please specify)</small> | |

RELEVANT CLINICAL INFORMATION (Must be provided) _____

Referring Physician Name:

Signature:

Date: (dd/mm/yyyy)

RADIOLOGIST USE ONLY

Clinical Indication <input type="checkbox"/> Breast Cancer Screening <input type="checkbox"/> Cancer Staging/Diagnosis <input type="checkbox"/> Other	Priority: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Timed: _____			Oral Administration + 500ml on table <input type="checkbox"/> Read-Cat® 2 <input type="checkbox"/> H ₂ O <input type="checkbox"/> Water Soluble	Rectal Administration <input type="checkbox"/> Water Soluble
	Special Instructions / For Radiologists & MRT(R) Only Radiologist: _____ <small>Name (print) Signature</small>	Unenhanced	Contrast Enhanced	Unenhanced & Contrast Enhanced	
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Thorax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

