STEVENSON MEMORIAL HOSPITAL
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 _____ µmol/L (ED patient: within 24 hrs or less. Inpatient: within 48 hrs or less)
Patient weight _____kg (Required if creatinine level > 130 µmol/L)
**OR** eGFR _____ mL/min/1.73 $m^2$
GFR _____ mL/min/1.73 $m^2$

**AREA TO BE SCANNED: *(check box)***

| | | | | |
|---|---|---|---|---|
| ☐ Head | ☐ Sinuses | ☐ C-Spine | ☐ Thorax | ☐ Neck |
| ☐ Facial Bones | ☐ Mastoids/Temporal Bones | ☐ T-Spine | ☐ Abdomen | ☐ Renal Stone Protocol |
| ☐ Orbits | ☐ Code Stroke EVT | ☐ L-Spine | ☐ Pelvis | ☐ Extremity |
| ☐ CTA _____ *(please specify)* | ☐ Other _____ *(please specify)* | | | ☐ R or ☐ L _____ *(please specify)* |

**RELEVANT CLINICAL INFORMATION *(Must be provided)*** _____

_____

_____

_____

**Referring Physician Name:** **Signature:** **Date: (dd/mm/yyyy)**

## RADIOLOGIST USE ONLY

**Clinical Indication**
☐ **Breast Cancer Screening**
☐ **Cancer Staging/Diagnosis**
☐ **Other**

**Priority:**
1 ☐ 2 ☐ 3 ☐ 4 ☐
**Timed:** _____

**Oral Administration + 500ml on table**
☐ **Readi-Cat® 2** ☐ **$H_2O$**
☐ **Water Soluble**

**Rectal Administration**
☐ **Water Soluble**

| | Unenhanced | Contrast Enhanced | Unenhanced & Contrast Enhanced |
|---|---|---|---|
| Head | ☐ | ☐ | ☐ |
| Neck | ☐ | ☐ | ☐ |
| Spine ☐ C ☐ T ☐ L | ☐ | ☐ | ☐ |
| Thorax | ☐ | ☐ | ☐ |
| Abdomen | ☐ | ☐ | ☐ |
| Pelvis | ☐ | ☐ | ☐ |
| Extremity | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

**Special Instructions / For Radiologists & MRT(R) Only**

Radiologist: _____ _____
Name (print) Signature