



HOSPITAL ID: _____

OUTPATIENT CT REQUISITION FORM

PATIENT INFORMATION						
SURNAME		FIRST NAME			MIDDLE INITIAL	
ADDRESS				CITY	PROVINCE	POSTAL CODE
MOBILE PHONE #		ALTERNATE PHONE #	EMAIL			
Patient consents to appointment information being disclosed to them via text or e-mail				☐ Yes, text		☐ Yes, e-mail
SEX ASSIGNED AT BIRTH ☐ Female ☐ Male		GENDER IDENTITY ☐ Female ☐ Male ☐ Other		DOB (YYYY/MM/DD)	HEIGHT(CM)	WEIGHT (KG)
HEALTH CARD NUMBER (HN)		VERSION CODE (VC)		WSIB CLAIM #	OTHER (self-pay, research, 3rd party payor)	
☐ INTERPRETER REQUIRED Preferred language		ACCESSIBILITY CONCERNS OR REQUIREMENTS				
ALTERNATE CONTACT (IF NOT PATIENT)	CONTACT NAME			CONTACT PHONE #		
EXAM INFORMATION AND HISTORY						
TEST/REGION(S) TO BE EXAMINED ☐ Head ☐ Brain ☐ Sinuses ☐ Facial Bones ☐ Temporal Bones ☐ Orbits ☐ Circle of Willis ☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacral/Coccyx ☐ Thorax ☐ Routine ☐ High-resolution ☐ Pulmonary Embolism ☐ Thorax/Abdomen /Pelvis ☐ Abdomen/Pelvis ☐ Routine ☐ Renal Colic ☐ Urography ☐ Enterography ☐ Musculoskeletal (please indicate) ☐ OTHER EXAM TYPE (please indicate)			REASON FOR EXAM /CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable) If the patient requires emergent attention, do not submit this form to Central Intake. Please contact your nearest imaging facility directly			
			☐ TIMED FOLLOW UP DATE REQUESTED (YYYY/MM/DD) CT availability is limited: requested dates will be accommodated where possible.			
SCREENING & PRECAUTIONS						
RENAL ASSESSMENT ☐ No known kidney issues ☐ Yes, patient has kidney problems, kidney transplant or is seeing a urologist If yes, check all that apply: ☐ Has diabetes ☐ On dialysis Please provide the most recent eGFR results (within the last 6 months) eGFR RESULT (ml/min/1.73²) DATE COLLECTED (YYYY/MM/DD)			☐ Known hypersensitivity to contrast agents ☐ Currently pregnant ☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable ☐ Requires general anesthesia Rationale For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.			
PREFERRED LOCATION						
All patients will be triaged to the shortest distance unless a preferred location is entered.			PREFERRED LOCATION(S)			
OTHER ROUTING CONSIDERATIONS						
REFERRING PROVIDER						
PROVIDER NAME			BILLING #		PROFESSIONAL ID	
ADDRESS			CITY	PROVINCE.	POSTAL CODE	
PHONE #		FAX #	COPY TO			
PROVIDER SIGNATURE					DATE	
OFFICE USE ONLY						
PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED ☐ Yes ☐ No		SPECIFIED DATE			
OH ☐ Cancer ☐ No	PROTOCOL			RADIOLOGIST		