IMAGING REQUISITION

CT REQUISITION

Phone: 519-272-8212
Fax: 519-272-8247

Patient Name:_____

ID Number: _____ DOB: _____

Phone: (___)_____ HC #_____

IMAGING DEPARTMENT USE ONLY:

Date: _____**Time:** _____ a.m. p.m.

☐ Please notify your patient of this appt.
☐ Your patient has been notified of this appt.
☐ Register in Imaging 1st Floor East Building North

PREP INFORMATION

☐ No Prep Required
☐ Bring list of medications
☐ Start IV # _____
☐ Drink 1 bottle of water en route and do not void.
☐ Clear Fluids only 4 hours prior
☐ Consent obtained by MRP
☐ Patient may be here 2+ hrs

Clinical Information (mandatory): _____

_____

Specific Relevant prior surgery:_____ ☐ PRIORITY DICTATION

Physician Name (please print):_____ _____ _____

Physician's Signature (mandatory) **Date**

Additional Copies to:_____

Computed Tomography (Stratford Only)

☐ Head (Brain)
☐ Sinus
☐ Facial Bone
☐ Temporal/ IAC
☐ Neck
☐ CT IVP
☐ Other_____

☐ Pulmonary Embolism
☐ Chest
☐ Abdomen/Pelvis
☐ Renal Colic
☐ CT Colonography
☐ Extremity R L _____

☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Bone Pelvis

Is the Patient:
☐ An Inpatient : _____
☐ In Isolation
☐ From Long Term Care: _____

Does the patient require:
☐ Wheelchair ☐ Walker
☐ Mechanical Lift ☐ Special Needs
☐ Other: _____

All the following questions must be completed before the CT will be booked.

1. Is the patient allergic to radiographic IV contrast? ☐Yes ☐No

2. (a) Is there a history of renal impairment or nephrectomy? ☐Yes ☐No
   (b) Is the patient currently on dialysis? ☐Yes ☐No
   (c) Is the patient over 70 years old? ☐Yes ☐No
   (d) Is the patient on any medications for diabetes? ☐Yes ☐No
   If yes, do they take medication called Metformin, Glucophage or Avandamet? ☐Yes ☐No
   (e) Does the patient have other medical conditions or take any medications that may predispose to nephrotoxicity? Please list: _____

If you answered yes to any of the items in Question 2 and your patient requires/ or may require IV Contrast, a recent creatinine (within 2 months) must be forwarded with the requisition.

Creatinine: _____ Date (YYYY/MM/DD): _____

3. Is the patient competant to sign consent? ☐Yes ☐No
4. Patient`s weight: _____lb/kg
5. Is there a history of pheochromocytoma, multiple myeloma or heart disease? ☐Yes ☐No
   Please list: _____
6. Has patient had any previous exams, relevant to this study? ☐Yes ☐No
   If yes, what and where: _____

RADIOLOGY USE ONLY:

eGFR: _____

Protocol: ☐ IV ☐ Oral Water ☐ Oral Gastro ☐ Rectal ☐ Chest LD

P1 P2 P3 P4 Timed **LH KS HN DM SM**