Reset

# DIAGNOSTIC IMAGING – CT

CT

Quinte Health

| | | |
|---|---|---|
| | MD Name: | Patient Name: |
| | Signature: | DOB: |
| | MD Phone: | HCN: |
| | Date: (d/m/y) | Home Phone: |
| **FAX ALL REQUISITIONS TO:** **613-969-5561** | Copies to: | Cell Phone: |
| | WSIB #: | Address: |

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

**AREA TO BE SCANNED:**

**CLINICAL INDICATION:**

**Requested CT date/time frame:**

**Note: DI Department will triage requests based on the provided history**

LOCATION: ☐ ED Patient Call Back ☐ ED Patient In Hospital ☐ Inpatient- Floor: ☐ Outpatient

**Please include relevant imaging reports from outside centres.**

**Relevant previous studies:** ☐ **US** ☐ **CT** ☐ **MRI** **Date:** **Facility:**

## CT

Patient Weight: _____lbs.
Note: CT table weight limit is 600 lbs.

Prior relevant surgeries:

_____

_____

| | Y | N |
|---|---|---|
| Pregnant | ☐ | ☐ |
| Smoker | ☐ | ☐ |
| Previous adverse IV contrast reaction | ☐ | ☐ |

If yes, specify:_____
Note: DI department can suggest a prophylaxis regimen by fax. The administration of such prophylaxis remains the responsibility of the referring physician.

| | Y | N |
|---|---|---|
| Age over 70?* | ☐ | ☐ |
| Chronic renal dysfunction or solitary kidney?* | ☐ | ☐ |
| Hypertension requiring medication?* | ☐ | ☐ |
| Diabetic?* | ☐ | ☐ |
| If yes, on Metformin? | ☐ | ☐ |

Note: Only patients with acute kidney injury or eGFR <30 will be advised to discontinue Metformin for 48 hours post IV contrast injection and have their renal function checked before restarting.

* **IF YES**, eGFR is required for IV contrast studies (within ≤ 6 months for stable outpatients, ≤ 7 days for inpatients, and same day for acutely ill patients.)

eGFR: ☐

Date of bloodwork: ☐

**DEPARTMENT USE ONLY**

Appointment Date & Time:_____

Technologist Initials:

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613- 969-5561

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