DIAGNOSTIC IMAGING – CT COLONOGRAPHY CT COLON

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

STUDY REQUESTED:

- ☐ Screening Colonography
- ☐ Colonography and Staging CT with IV Contrast
- ☐ Completion of incomplete OC (if same day request, must call radiologist)

CLINICAL INDICATION:

LOCATION: ☐ Endo ☐ Inpatient- Floor: ☐ Outpatient

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

	Y	N
Prior Optical Colonoscopy (please include most recent report)	☐	☐
Bowel Surgery < 6 weeks	☐	☐
Deep Colonic Biopsy < 1 week	☐	☐
Superficial Colonic Biopsy < 1 week	☐	☐
Simple Polypectomy < 1 week	☐	☐
Active Colitis/Acute Abdominal Disease	☐	☐
Personal history of Colorectal Cancer	☐	☐
Pregnant	☐	☐
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.

Complete only if requiring Staging CT with IV Contrast

	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