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:

PREFERRED HOSPITAL: ☐ **BGH** ☐ **TMH** ☐ **NHH**

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