HEADWATERS Health Care Centre

CT REQUISITION (519) 941-2410

Today's Date: _____Patient Transport: ☐ W/C ☐STRETCHER

PATIENT'S NAME_____HC#_____

ADDRESS_____

BIRTHDATE_____TELEPHONE_____

ORDERING M.D._____TELEPHONE_____

PLEASE FILL IN ALL INFORMATION TO PREVENT ANY DELAY IN BOOKING APPOINTMENT TIMES

AREA(S) TO BE SCANNED:

RELEVANT CLINICAL INFORMATION (MUST BE PROVIDED OR APPOINTMENT CANNOT BE BOOKED):

PREVIOUS CT: YES NO WHERE: _____

PREVIOUS SURGERY: _____

PLEASE PROVIDE REPORTS OF ANY RELEVANT IMAGING EXAMINATIONS

DIABETIC: ☐YES ☐ NO METFORMIN: ☐YES ☐ NO PATIENT WEIGHT: _____ ☐ lbs ☐ kg DOES PATIENT HAVE SPECIAL REQUIREMENTS FOR TRANSPORT? DESCRIBE:	RENAL FUNCTION: ☐NORMAL ☐ ABNORMAL STATE CREATININE AND DATE OF RESULT CREATININE_____ DATE:_____ EGFR_____ Radiologist Initial ☐
PREVIOUS ALLERGY TO CONTRAST ☐ YES ☐ NO	REFERING PHYSICIAN SIGNATURE:
DOES PATIENT HAVE A POWER PORT? ☐ YES ☐ NO	ADDITIONAL COPIES TO:
Patient/SDM must be able to provide consent at the time of the CT scan	

PLEASE RETURN BY FAX TO (519) 941-5919

PATIENT /FLOOR WILL BE INFORMED OF APPOINTMENT TIME

APPOINTMENT DATE: _____ **Time:** _____

FOR DIAGNOSTIC IMAGING USE ONLY: DATE RECEIVED: FROM: TO:	RADIOLOGIST PROTOCOL: ☐1 ☐2 ☐3 ☐4 Radiologist Initial ☐

FROM:	TO:	