

Diagnostic Imaging Requisition
Booking Office

Phone: 519-941-2410 Ext. 2211

Fax: 519-941-7726

Today's Date: _____

 Patient Transport: W/C Stretcher

Patient

DOB

Address

Phone #

Health Card#

Ordering M.D.

Telephone #

CT Requisition

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 If yes, where:

PLEASE PROVIDE REPORTS OF ANY RELEVANT IMAGING EXAMINATIONS

 Diabetes: Yes No

 Metformin: Yes No

 Patient Weight: _____ lbs kg

 Does Patient have special transport requirements? Yes No

Describe:

Renal Assessment:

 Is the patient on dialysis: Yes No

 Does your patient have kidney problems or a kidney transplant: Yes No

 Has your patient seen or are they waiting to see a nephrologist or urologist: Yes No

 If you answered "yes" to any of the above Renal Assessment Questions, a Creatinine and eGFR within **6 months** of the appointment must be provided.

Test	Result	Date
Creatinine		
eGFR		

 Previous allergy to contrast? Yes No N/A

Referring Physician Signature:

 Does patient have a PICC or power port? Yes No

Additional Copies To:

 Initial in box to proceed without bloodwork.
 (Emergency Department Only)

Patient/ SDM must be able to provide consent at the time of the CT scan

Please return by fax to (519) 941-7726

Patient/Department will be informed of appointment date/time.

Appointment Date: _____ Time: _____