HEADWATERS
Health Care Centre

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	Renal Assessment:		
Metformin: ☐ Yes ☐ No	Is the patient on dialysis:	☐ Yes ☐ No	
Patient Weight: ☐ lbs ☐ kg	Does you patient have kidney problems or a kidney transplant:	☐ Yes ☐ No	
Does Patient have special transport requirements? ☐ Yes ☐ No	Has you patient seen or are they waiting to see a nephrologist or urologist:	☐ Yes ☐ No	
Describe:	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:		
Patient/ SDM must be able to provide consent at the time of the CT scan			

Please return by fax to (519) 941-7726
Patient/Floor will be informed of appointment time.

Appointment Date: _____ **Time:** _____