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

Diabetic: ☐ Yes ☐ No Metformin: ☐ Yes ☐ No Patient Weight: ______________ ☐ lbs. ☐ kg Does Patient have special transport requirements? ☐ Yes ☐ No Describe:	Renal function: ☐ Normal ☐ Abnormal State Creatine and date of result: Creatine: ________________ Date: ___________________ EGFR: __________________________ ***Contrast studies cannot be booked without recent bloodwork**.
Previous allergy to contrast? ☐ Yes ☐ No	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:**____