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#** _____

Email Address _____

Ordering M.D. _____ **Telephone #** _____

CT Requisition

Clear Form

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:
Can the patient give consent? ☐ Yes ☐ No	
Initial in box to proceed without bloodwork. **(Emergency Department Only)**	

POST CT FOLLOW UP:

☐ PATIENT TO FOLLOW UP IN EMERGENCY DEPARTMENT ☐ PATIENT TO FOLLOW UP WITH FAMILY DOCTOR

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:** _____