

# Medical Imaging CT Request Form



- 600 University Av. Toronto, Ont. T • 416-586-4418 F • 416-586-3180
- TGH 585 University Av. Toronto, Ont.  TWH 399 Bathurst St. Toronto, Ont.  PM 610 University Av. Toronto, Ont. T • 416-340-3384 F • 416-340-4661
- 76 Grenville St. Toronto, Ont. T • 416-323-7515 F • 416-323-6316

Date: \_\_\_\_\_  
yyyy / mm / dd

## PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL BE RETURNED

SURNAME	GIVEN NAME
BIRTHDATE: YYYY MM DD	HOSPITAL MEDICAL RECORD NO.
<b><u>PATIENT EMAIL ADDRESS:</u></b>	
ADDRESS: (Street, Apt. #:)	
CITY/TOWN	PROVINCE
POSTAL CODE	
MOBILE PHONE NUMBER (preferred) (Area Code & Number)	
(        ) _____ - _____	
Health Card Number	Version Code
EXAMINATION(S)	
Clinical History and Indications:	
<input type="checkbox"/> Routine <input type="checkbox"/> Emergent <input type="checkbox"/> Acute	

**The following MUST be completed by the referring provider: (Please check)**

1. Does the patient have a history of **Kidney disease?** Yes  No   
(eg. 1 kidney, renal failure, dialysis)

2. Is the patient diabetic? Yes  No

3. Previous reaction to IV contrast? Yes  No

4. Does the patient have a pelvic/ileoanal pouch? Yes  No

**If YES to question #1 or #2, please provide blood work (must be within the last 3 months)**

Creatinine \_\_\_\_\_ eGFR \_\_\_\_\_ Date: \_\_\_\_\_

**List Diabetic Medications:**

**Known Allergies:**

***IF THE PATIENT HAS A KNOWN CONTRAST ALLERGY, THE REQUESTING PHYSICIAN IS RESPONSIBLE FOR ORGANIZING THE PRE-MEDICATION PRIOR TO THE PATIENTS SCAN, PLEASE FOLLOW THE PRE-MEDICATION INSTRUCTIONS BELOW:***

**PREDNISONE 50mg P.O 13 HOURS AND 1 HOUR PRE-EXAMINATION PLUS BENADRYL 50mg P.O 1 HOUR PRE-EXAMINATION.**

**NOTE: BENADRYL CAN CAUSE DROWSINESS, PATIENTS SHOULD MAKE ARRANGEMENTS TO BE DRIVEN TO AND FROM THE EXAMINATION.**

Patient Weight: \_\_\_\_\_ kg/lbs.  
Date of last LMP: \_\_\_\_\_  
yyyy / mm / dd

Previous applicable surgery: \_\_\_\_\_ Relevant post-surgery & medical therapy \_\_\_\_\_



REFERRING PROVIDER INFORMATION	
Name and Initials (Print):	Provider's Signature: <span style="float: right;">REQUIRED</span>
Telephone #: (        )	Fax #: (        )
Requested Appointment Date (if applicable):	Billing & CPSO # <span style="float: right;">REQUIRED</span>
Provider's Address:	

CC report to: \_\_\_\_\_

Interpreter required if **YES** what language: \_\_\_\_\_