

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Imaging - FAX: 905-830-5966

Health Record #: _____ Complete or place barcoded patient label here
 Patient Name: *(Print first, last)* _____
 DOB: dd / mm / yy Age: _____ Female Male
 OHIP #: _____ Version Code: _____
 Phone #: _____

OUT-PATIENT IN-PATIENT ED PATIENT ED CALLBACK

CT Requisition

Patient Name: <i>(print first, last)</i>		Appointment Date: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Address: _____		Appointment Time: _____	
City	Street Number + Name	Apartment	Postal Code
Health Card Number:		Version Code:	
Other Insurance:		WSIB Number:	
Home: ()		Work/Other: ()	
Patient not available: From: <u>dd</u> / <u>mm</u> / <u>yy</u> To: <u>dd</u> / <u>mm</u> / <u>yy</u>		Date of Birth: ____/____/____	
Reason:		Patient Weight: _____ kg	
Area to be scanned:		RENAL FUNCTION ASSESSMENT <i>(please check (✓) appropriate)</i>	
Clinical Question:		<input type="checkbox"/> Hx of Renal Disease:	
RELEVANT CLINICAL INFORMATION: <i>(must be provided and please be specific)</i>		Creatinine= _____ obtained on <u>dd</u> / <u>mm</u> / <u>yy</u>	
		eGFR= _____	
		<input type="checkbox"/> On Dialysis: Does the patient make greater than 100ml of urine per day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Acute Kidney Injury (AKI): for IN-patient/ED patients only	
		<input type="checkbox"/> The patient has NONE of the above risk factors.	
		Venous Access in situ: <input type="checkbox"/> Port <input type="checkbox"/> PICC	
		Allergy to contrast <input type="checkbox"/>	
Referring Physician: <i>(print first, last)</i>		CPSO #	Date: <u>dd</u> / <u>mm</u> / <u>yy</u>
Signature:		Office Phone: ()	
Address:		Fax Number: ()	

RADIOLOGIST USE ONLY			
Head	<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With Contrast	Protocol Notes: <input type="checkbox"/> With Oral Contrast
Neck	<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With Contrast	
Thorax	<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With Contrast	
Abdomen	<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With Contrast	
Pelvis	<input type="checkbox"/> Without Contrast	<input type="checkbox"/> With Contrast	
Triphasic Liver	<input type="checkbox"/> Without Pelvis	<input type="checkbox"/> With Pelvis	
Renal Mass	<input type="checkbox"/> Without Pelvis	<input type="checkbox"/> With Pelvis	
Pancreas	<input type="checkbox"/> Without Pelvis	<input type="checkbox"/> With Pelvis	
Facial Bones	<input type="checkbox"/> Without Mandible	<input type="checkbox"/> With Mandible	
Spine	<input type="checkbox"/> C-spine	<input type="checkbox"/> L3 to S1	
	<input type="checkbox"/> Other _____		
High Res Chest	<input type="checkbox"/> Inspiration	<input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Interstitial	
Thorax	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Dissection	
Abdomen	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Dissection	
Pelvis	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Dissection	
<input type="checkbox"/> Sinuses	<input type="checkbox"/> Wrist	<input type="checkbox"/> Pulmonary Angio	Priority: <i>(please circle)</i> 1 2 3 4 Is this a specified date (timed) procedure? If yes, specify date: _____
<input type="checkbox"/> Renal Colic	<input type="checkbox"/> Hip	<input type="checkbox"/> Carotid Angio	
<input type="checkbox"/> Urogram	<input type="checkbox"/> Ankle/Foot	<input type="checkbox"/> Circle of Willis	
			Clinical Indications for Scan: <input type="checkbox"/> Cancer Staging and/or Diagnosis <input type="checkbox"/> Other Diagnosis
			Radiologist/MRT (R): <i>(print first, last)</i>
			Radiologist/MRT (R) Signature:

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Diagnostic Imaging

Patient Preparation and Information

Patient Preparation for CT Abdomen and/or Pelvis:

- Drink 1 litre of water 1 hour prior to scan time.
- Take medication(s) as usual.

PATIENT INFORMATION:

- **Bring your Ontario Health Card.**
- Upon arrival you are required to register for your appointment at one of our Welcome Centres before proceeding to Diagnostic Imaging Reception on East 2.
- If you are unable to keep your appointment, please call Patient Scheduling at 905-895-4521, ext. 2665.