

Health Record #:	_____ Complete or place barcoded patient label here		
Patient Name: <i>(Print first, last)</i>	_____		
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
OHIP #:	Version Code: _____		
Account #:	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>		

Coronary CT Angiography 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
Province		Arrival Time:	
Health Card Number:		Version Code:	
Other Insurance:		WSIB Number:	
Home: ()		Work/Other: ()	
Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>		Hospital Record #:	
Patient Weight: _____		kg	
Patient not available: From: <u>dd</u> / <u>mm</u> / <u>yy</u> To: <u>dd</u> / <u>mm</u> / <u>yy</u> Reason: _____			

CLINICAL INFORMATION:

 History of CABG Yes No If yes, specify: _____

 History of coronary stent(s) insertion Yes No If yes, specify: _____

Diagnostic question/clinical history: _____

CONTRAINDICATIONS TO METOPROLOL

Heart Block If yes, circle degree: 1 2 3 Yes No

Left/Right ventricle failure Yes No

Is there a Grade IV left ventricle or has there been any admission in the last 6 months for CHF?

If yes, provide the most recent LVEF= _____ %

Pulmonary arterial hypertension Yes No

If yes, provide RSVP= _____ mmHg

Asthma/COPD Yes No

 Any hospital admission in the past 6 months? Yes No

 Regular use of puffers? If yes, - most recent FEV1= _____ Yes No

Allergy to Metoprolol Yes No

CONTRAINDICATIONS TO SUBLINGUAL NITROGLYCERIN

 Using Sildenafil or equivalent (Viagra/Cialis) Yes No

If YES*, discontinue 48 hours prior to appointment date and time.

 Severe aortic stenosis Yes No

 Severe anaemia Yes No

 Closed angle glaucoma Yes No

 Increased intracranial pressure Yes No

 Recent myocardial infarction Yes No

 Hypersensitivity to nitroglycerin Yes No

CONTRAINDICATIONS TO CT CORONARY ANGIO

 Is there a history of allergy to iodinated contrast media? Yes No

If yes, provide details (e.g. hives, breathing difficulties, cardiorespiratory arrest): _____

 Is there a history of renal disease? Yes No

If yes, provide the most recent serum creatinine = _____

 Is there a history of chronic atrial fibrillation? Yes No

 Is the patient pregnant? Yes No

 Does your patient have **Diabetes mellitus:** Yes No

Please include the following, if not available at Southlake:

Most recent creatinine/eGFR (in the last 6 months): attach to requisition

12 lead ECG and/or rhythm strip

Any relevant consultation letter(s)

Any notes re: stents or bypass grafts

Results of any prior tests (e.g. echocardiograms, stress tests, nuclear medicine tests, angiography)

List Current Medications

DIAGNOSTIC IMAGING USE ONLY Protocol: Coronary CT Angiogram Pulmonary Vein Priority Level 4, Other Diagnosis

Cardiologist/Radiologist Name: *(print first, last)*
Signature:

** Please give your patient the Coronary CT Angiography Patient Guide - SL0179

Referring Physician: <i>(print first, last)</i>	CPSO #	Date: <u>dd</u> / <u>mm</u> / <u>yy</u>
Signature:	Office Phone: ()	
Address:	Fax Number: ()	