

Referring Physician: (print first, last): \_\_\_\_\_  
 CPSO# \_\_\_\_\_ Signature: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Date: dd / mm / yy

## CT Requisition

Please fax to (905) 830-5966

<b>Patient Name:</b> (print first, last) _____		<b>Date of Birth:</b> <u>dd</u> / <u>mm</u> / <u>yy</u>
<b>Address:</b>	Street Number + Name _____	Apartment _____
	City _____ Province _____	Postal Code _____
<b>Health Card Number:</b>	<b>Version Code:</b>	<b>Home:</b> ( ) _____
<b>Other Insurance:</b>	<b>Email:</b> _____	
<b>Patient DOES NOT consent to be contacted via:</b> <input type="checkbox"/> Text <input type="checkbox"/> Email (for patient privacy information see the next page)		
<b>Patient not available:</b> From: <u>dd</u> / <u>mm</u> / <u>yy</u> To: <u>dd</u> / <u>mm</u> / <u>yy</u>		
<b>Hoyer Lift Required?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Patient arriving by Ambulance Transfer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Clinical Question and Relevant Clinical Information:</b> (must be provided and please be specific)		<input type="checkbox"/> Cancer diagnosis or staging?
<b>EXAM REQUIRED</b> (check all that apply)		
<b>Head/Neck</b> <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Orbits Sinus: <input type="checkbox"/> Routine <input type="checkbox"/> Landmark (ENT) Facial Bones: <input type="checkbox"/> With Mandible <input type="checkbox"/> Without Mandible <input type="checkbox"/> Temporal Bone (Middle Ear) and Mastoids <input type="checkbox"/> IACs (Acoustic)	<b>Thorax/Abdomen/Pelvis</b> <input type="checkbox"/> Abdomen <input type="checkbox"/> Thorax <input type="checkbox"/> Pelvis (Soft Tissue) <input type="checkbox"/> Pelvis (Bony) High Resolution Chest: <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Interstitial Kidney (Renal Mass): <input type="checkbox"/> With Delayed Bladder <input type="checkbox"/> Without Delayed Bladder Liver (Triphasic): <input type="checkbox"/> Routine with Pelvis <input type="checkbox"/> Routine without Pelvis <input type="checkbox"/> Adrenals Pancreas: <input type="checkbox"/> Routine with Pelvis <input type="checkbox"/> Routine without Pelvis <input type="checkbox"/> Urogram <input type="checkbox"/> Renal Colic <input type="checkbox"/> Enterography	<b>Musculoskeletal</b> Shoulder <input type="checkbox"/> Right <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right <input type="checkbox"/> Left Wrist <input type="checkbox"/> Right <input type="checkbox"/> Left Hand <input type="checkbox"/> Right <input type="checkbox"/> Left Hip <input type="checkbox"/> Right <input type="checkbox"/> Left Knee <input type="checkbox"/> Right <input type="checkbox"/> Left Ankle <input type="checkbox"/> Right <input type="checkbox"/> Left Foot <input type="checkbox"/> Right <input type="checkbox"/> Left Pelvis <input type="checkbox"/> Right <input type="checkbox"/> Left Other – Specify: <input type="checkbox"/> _____
<b>Spine</b> <input type="checkbox"/> Cervical – Specify Levels: _____ <input type="checkbox"/> Thoracic – Specify Levels: _____ <input type="checkbox"/> Lumbar – Specify Levels: _____ <input type="checkbox"/> SI Joints – Bilateral <input type="checkbox"/> Sacrum and Coccyx	<b>Cardiac</b> <input type="checkbox"/> Cardiac Calcium Score <input type="checkbox"/> AV Calcium Score <small>For Angiography, please fill out the Coronary CT Angiogram requisition located on our website</small>	<b>Angiography</b> <input type="checkbox"/> Carotid (includes Circle of Willis) <input type="checkbox"/> Circle of Willis Only <input type="checkbox"/> Pulmonary Angiogram <input type="checkbox"/> Renal/Mesenteric Angiogram <input type="checkbox"/> Runoff Aortogram <input type="checkbox"/> Thoracic <input type="checkbox"/> Abdomen (Aneurysm) <input type="checkbox"/> Pelvis Aortogram <input type="checkbox"/> Thoracic <input type="checkbox"/> Abdomen (Dissection) <input type="checkbox"/> Pelvis
<b>Other Request (not listed above)</b> Specify: _____		<b>Endovascular Aneurysm Repair (EVAR)</b> Abdo/Pelvis: <input type="checkbox"/> Post EVAR <input type="checkbox"/> EVAR Leak Thoracic: <input type="checkbox"/> Post EVAR
<b>Renal Function Assessment</b> (check appropriate) <input type="checkbox"/> History of Renal Disease: 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 <input type="checkbox"/> Allergy to contrast		<b>ED USE ONLY</b> Suspected <input type="checkbox"/> Appendicitis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Pancreatitis BMI _____ kg/m (must be greater than 25kg/m <sup>2</sup> ) Abdo/pelvis surgery in the last 2 weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No



Diagnostic Imaging

***CT 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.



**PRIVACY POLICY DOCUMENTATION**  
via QR code link below or via Southlake's  
privacy office webpage