SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Imaging

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 #: _____

CT Requisition

❑ OUT-PATIENT ❑ IN-PATIENT ❑ ED PATIENT ❑ ED CALLBACK ***Please fax to (905) 830-5966***

Patient Name: *(print first, last)*

Address: Street Number + Name Apartment

City Province Postal Code

Health Card Number: **Version Code:**

Other Insurance: **WSIB Number:**

Home: ( ) **Work/Other:** ( )

Patient not available: From: dd / mm / yy To: dd / mm / yy

Area to be scanned:

Clinical Question:

RELEVANT CLINICAL INFORMATION:
(must be provided and please be specific)

ED USE ONLY:
suspected ❑ appendicitis
❑ diverticulitis
❑ pancreatitis

BMI_____ kg/m
(must be greater than 25 kg/m^2)

Abdo/pelvis surgery in last 2 weeks: ❑ Yes ❑ No

❑ Waive Creatinine

Appointment Date: dd / mm / yy
Appointment Time:
Arrival Time:
Hospital Record #:
Date of Birth: _____/_____/_____
Patient Weight: _____ **kg**

RENAL FUNCTION ASSESSMENT
(please check (✓) appropriate)
❑ Hx of Renal Disease:
Creatinine= _____ obtained on dd / mm / yy
eGFR= _____
❑ On Dialysis: Does the patient make greater than 100ml of urine per day? ❑ Yes ❑ No
❑ Acute Kidney Injury (AKI): for IN-patient/ ED patients only
❑ The patient has **NONE** of the above risk factors.

Venous Access in situ: ❑ Port ❑ PICC

Allergy to contrast ❑

Referring Physician: *(print first, last)* **CPSO #** **Date:** dd / mm / yy

Signature: **Office Phone:** ( )

Address: **Fax Number:** ( )

RADIOLOGIST USE ONLY

Head	❑ Without Contrast	❑ With Contrast	
Neck	❑ Without Contrast	❑ With Contrast	
Thorax	❑ Without Contrast	❑ With Contrast	
Abdomen	❑ Without Contrast	❑ With Contrast	
Pelvis	❑ Without Contrast	❑ With Contrast	
Triphasic Liver	❑ Without Pelvis	❑ With Pelvis	
Renal Mass	❑ Without Pelvis	❑ With Pelvis	
Pancreas	❑ Without Pelvis	❑ With Pelvis	
Facial Bones	❑ Without Mandible	❑ With Mandible	
Spine	❑ C-spine	❑ T-spine	❑ L-spine
High Res Chest	❑ Inspiration	❑ Bronchiectasis	❑ Interstitial
Thorax	❑ Aneurysm	❑ Dissection	❑ Post EVAR
Abdomen	❑ Aneurysm	❑ Dissection	❑ Post EVAR
Pelvis	❑ Aneurysm	❑ Dissection	❑ Post EVAR

❑ **Temporal Bones**	❑ **CT Enterography**	❑ **CTA Runoff**
❑ **Sinuses**	❑ **Wrist**	❑ **Pulmonary Angio**
❑ **Renal Colic**	❑ **Hip**	❑ **Carotid Angio**
❑ **Urogram**	❑ **Ankle/Foot**	❑ **Circle of Willis**

Protocol Notes:
❑ With Oral Contrast

Priority: *(please circle)*
1 2 3 4

Is this a specified date (timed) procedure?
If yes, specify date: _____

Clinical Indications for Scan:
❑ Cancer Staging and/or Diagnosis
❑ Other Diagnosis

Radiologist/MRT (R): *(print first, last)*

Radiologist/MRT (R) Signature:

The collecting of personal information on this form is done in accordance with Southlake's Privacy Policy. Details are available on our website, www.southlake.ca

SL0260_28 (11/24) "Diagnostic Imaging" Review (11/27)

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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.

SL0260_28 (11/24) "Diagnostic Imaging" Review (11/27)