SOUTHLAKE
REGIONAL HEALTH CENTRE

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: _____
Account #: _____ Date of Admission: dd / mm / yy

Coronary CT Angiography Requisition

Patient Name: *(print first, last)*		**Appointment Date:** dd / mm / yy
Address: Street Number + Name	Apartment	**Appointment Time:**
City	Province / Postal Code	**Arrival Time:**
Health Card Number:	**Version Code:**	**Hospital Record #:**
Other Insurance:	**WSIB Number:**	**Date of Birth:** dd / mm / yy
Home: ( )	**Work/Other:** ( )	**Patient Weight:** _____ **kg**

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

Allergy to Metoprolol	☐ Yes	☐ No
AV Heart Block	☐ Yes	☐ No
Grade IV left ventricle	☐ Yes	☐ No
Hospital admission in past 6 months for CHF/COPD/Asthma or regular use of puffers	☐ Yes	☐ No
Pulmonary arterial hypertension	☐ 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
If patient is on Hemodialysis, provide schedule (i.e., MWF 14:00 hrs): _____

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: *(print first, last)*	**CPSO #**	**Date:** dd / mm / yy
Signature:		**Office Phone:** ( )
Address:		**Fax Number:** ( )

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