Campbellford Memorial Hospital

CT REQUISITION

Please fax completed requisition to the Bookings department:

Fax: 705-653-3601

Phone: 705-653-1140 ext. 2108

Physician Information (Print or Imprint Below)

Name:

Billing #:

Phone #:

Fax #:

Copies To:

Patient Information (Print or Place Sticker Below)

Last Name: _____

First Name: _____

Address: _____

Address: _____

City:_____ P. Code:_____

D.O.B. ____/____/_____
Day Month Year

Phone #: _____

Health Card: __ __ __ __ __ __ __ __ __ __ __ __

WSIB #: _____

Exam Priority: TIMED ☐ ROUTINE ☐ URGENT ☐ TODAY ☐

Requested Date/Time frame:

Area(s) to be Scanned

☐ Head ☐ Sinus ☐ Neck ☐ Thorax

☐ Abdomen ☐ Pelvis ☐ Extremity: _____

☐ Angio ☐ C-Spine ☐ T-Spine ☐ L-Spine

☐ Colonography ☐ Other: _____

Previous Relevant Imaging Yes ☐ No ☐ Date: _____

Facility:

History:

Date Physician's Signature

Patient Information Must be Complete or Requisition will be returned

Required Information For All CT Patients

Diabetes Mellitus	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐
Multiple Myeloma	Yes ☐	No ☐
Is Pt at Risk for Contrast Induced Nephropathy?	Yes ☐	No ☐
Metformin	Yes ☐	No ☐

IF PATIENT IS ON METFORMIN, STOP MEDICATION 24 HRS PRIOR TO EXAMINATION, AND FOR AN ADDITIONAL 48 HRS AFTER THE EXAMINATION

Pt over 70 Years of Age or at Risk for CIN	Yes ☐	No ☐

Serum Creatinine: _____

eGFR: _____

Date of Bloodwork: _____

CC to CMH CT Dept Yes ☐ No ☐

Allergies

X-Ray Dye	**Yes**	☐	**No**	☐
Food	**Yes**	☐	**No**	☐
Drugs	**Yes**	☐	**No**	☐
Environmen	**Yes**	☐	**No**	☐
Latex	**Yes**	☐	**No**	☐

Comments:

THE HEALTH PRACTITIONER PROPOSING TREATMENT IS RESPONSIBLE FOR OBTAINING THE CONSENT TO TREATMENT

ALL OF THE ABOVE MUST BE FILLED IN BY PHYSICIAN OR THE REQUISITION WILL BE RETURNED