CAMPBELLFORD MEMORIAL HOSPITAL

CT REQUISITION

CT Department extension 2154	705-653-1140

Emergent ☐	In Patient ☐	Out Patient ☐

☐ Isolation Type _____

Exam Priority

TODAY ☐	URGENT ☐	ELECTIVE ☐
	WITHIN 1 WEEK	Next Available Appt

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:_____

Phone:_____-_____-_____ D.O.B. ____/____/_____ (Day / Month / Year)

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

WSIB #:

Patient Information Must be Complete or Requisition will be returned

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

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

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**	☐
Environmental	**Yes**	☐	**No**	☐
Latex	**Yes**	☐	**No**	☐

Comments:

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

THIS AREA FOR RADIOLOGY USE ONLY

Circle Priority:	1	2	3	4	CT NOT INDICATED

PLEASE FAX COMPLETED REQUISITION TO 705-653-3601

780-220-12-9