CAMPBELLFORD MEMORIAL HOSPITAL CTREQUISITION Patent Information (Print or Place Sticker Below)									
CT Department extension 2154 705-653-1140				ame:	Patient Information (Pri				
Emergent 🗆	In Patient D	Out Patient		First Name:					
□ Isolation	Гуре								
Exam Priority Ad				ss:					
TODAY 🗆				Address:					
WITHIN 1 WEEK Next Available Appt									
Name:	nformation (Print C	or imprint Below)			_				
Billing #:									
Phone:			lioun						
Copies To:			WSIB #	Patient I	nformation Must be Com				
Area(s) to be Scanned					Required Information For All CT Patients				
Head	Sinus	□ Neck □ Thor		Diabetes Mellitus			s 🛛	No 🗌	
Abdomen	Pelvis	Extremity					s 🛛	No 🗆	
🗌 Angio	C-Spine	🗌 T-Spine 🗌 L-Sp	oine	Multiple M	-	Ye	s 🛛	No 🗌	
Colonography Previous Relevant	Colonography Other: Previous Relevant Imaging Yes No Date:				Is Pt at Risk for Contrast Induced Nephropathy?			No 🗆	
Facility:				Metformin	Y۵	Yes 🛛 🛛 No 🗌			
History:			IF PATIENT IS ON METFOR				_		
	PRIOR TO EXAMINATION, AND FOR AN ADDITIONAL 48 HF AFTER THE EXAMINATION								
				Pt over 70 Years of Age or at Risk for CIN		l Ye	s 🛛	No 🗆	
				Serum C	Creatinine				
	eGFR:								
				Date of Bloodwork:					
				CC to CMH CT Dept		Ye	s 🗌	No 🗌	
				Allergies					
				X-Ray D)ye Ye	es 🗌	No		
				Food	Ye	s 🗌	No		
				Drugs	Ye	es ∏	No		
Date		Physician's Signature		Environ	mental Ye	s ⊓	No		
				Latex	Ye	s ⊓	No		
THE HEALTH PR	ACTITIONER P	ROPOSING TREATM	IENT IS	4 1					
RESPONSIBLE FOR OBTAINING THE CONSENT TO TREATMENT									
ALL OF THE	ABOVE MUST B	E FILLED IN BY PHY	SICIAN	OR THE R	EQUISITIO	N WILL E	BE RET	TURNED	
THIS AREA FOR RADIOLOGY USE ONLY									
	1	1 1							
Circle Priority: 1 2 3 4 CT NOT INDICATED									
PLEASE FAX COMPLETED REQUISITION TO 705-653-3601									