UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute
Tel: 416-340-3384
Fax: 416-340-4661

WCHH WOMEN'S COLLEGE HOSPITAL Health care for women | REVOLUTIONIZED
Tel: 416-323-6400 ext.4833
Fax: 416-323-6316

CT CARDIAC REQUISITION

Patient Information

Medical Record #: _____ Health Card #:_____ Version Code: _____

Name:_____ _____ DOB: _____/ _____/ _____ Sex: ☐ M ☐ F
First Name *Last Name* *yyyy* *mm* *dd*

Address: _____ City: _____ Prov.: _____ Postal Code:_____

Home Tel.: _____Cell: _____ Business Tel.: _____

Mobility Status: ☐ Walking ☐ Wheelchair ☐ Stretcher ☐ Ambulance ☐ Other:_____

Billing Information: ☐ OHIP ☐ WSIB ☐ Non Resident/ Other Claim/Insurance # (with attachments): _____

FOR PATIENT SAFETY THESE QUESTIONS MUST BE ANSWERED:

Does any of the following apply? *(check all that apply)*

YES	NO	
☐	☐	Diabetes
☐	☐	Renal Disease
☐	☐	Pregnancy
☐	☐	Treatment with Sildenafil or similar medication
☐	☐	Status post CABG (Coronary Bypass Surgery)
☐	☐	Status post Coronary Stent/PCI
☐	☐	Heart Block
☐	☐	Aortic Stenosis
☐	☐	Any other Cardiac Surgery/ Intervention?

If Yes, please specify: _____

☐ ☐ History of allergic reaction to IV contrast in last 10 years?

If **Yes**, please describe (hives, cardiorespiratory arrest, etc.):

_____

_____

☐ ☐ Does the patient require an interpreter?
If **Yes**, what language?_____

Weight: _____

Height: _____

eGFR: _____

Clinical Information /Working Diagnosis:

_____

_____

_____

_____

_____

_____

_____

Completed Tests and Associated Results

Sites: ☐ Sinai Health System (SHS)
☐ University Health Network (UHN)
☐ Women's College Hospital (WCH)
☐ Other hospital/clinic *(attach outside report(s))*

Tests:_____

REFERRING HEALTHCARE PROVIDER *(REQUIRED)*

Referrer's Name:

_____ _____ _____
First name Last name Middle initial

Address:_____

City: _____ Postal Code:_____

Telephone: _____

Fax: _____ Billing number: _____

IMPORTANT INSTRUCTIONS for Referring Physicians

If the patient has diabetes or impaired renal function, you must submit eGFR results done within 3 months of the CT appointment. For all Trans Aortic Valve Implantation (TAVI) requests, eGFR is mandatory. **Submit all surgical reports available.**

Referrer's Signature: X _____ Date: _____

INCOMPLETE/ILLEGIBLE REQUESTS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT. FORM MUST BE COMPLETE, INCLUDING CLINICAL & SAFETY INFORMATION AND PHYSICIAN SIGNATURE