Women's College Hospital

Department of Medical Imaging
CT Scan Requisition
Appointment Phone # 416-323-7515
Medical Imaging Fax # 416-323-6316

LAST NAME _____ CHART # _____
FIRST NAME _____ D.O.B. _____
ADDRESS _____
_____
PHONE # _____
OHIN _____

Referring Physician:
Name: _____ Telephone: _____
Address: _____ Fax: _____
_____

M.D.'s Signature: _____
Diagnostic Report to:
☐ _____Nursing Unit ☐ _____Clinic ☐ Private Office ☐ Emergency ☐ Other Physician _____
Mode of Transportation: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher

Examination Requested:
HEAD: ☐ Routine ☐ Post Fossa ☐ Sinuses ☐ Other _____
CHEST: ☐ Routine ☐ HRCT ☐ Other _____
ABDOMEN/PELVIS: ☐ Routine ☐ Other
SPINE: Levels _____
EXTREMITY: ☐ Right ☐ Left _____
OTHER: _____
Provisional Diagnosis: _____
Relevant Clinical Data: _____
_____
_____

Relevant Previous Investigations: _____
Please ask patients to bring relevant outside films. Thank you.
Previous Surgery: _____
Current Medications: _____

Risk Factors:
Allergies: ☐ No ☐ Yes If yes please list: _____
Diabetes: ☐ No ☐ Yes Is patient on metformin? ☐ No ☐ Yes
Renal Failure: ☐ No ☐ Yes BUN _____ Creatine _____
Previous reaction to contrast media ☐ No ☐ Yes, describe _____
Date of LMP _____

For Medical Imaging Use Only

C- C+ C-/+ Book after 9:00

Routine Urgent Stat
Patient Arrival prior to app't: 15 minutes 2 hours
Date of Exam _____ Time Booked _____
R# _____ Booked by _____
Referring Physician Office Notified Date _____

Women's College Hospital

OUTPATIENT USE ONLY