Medical Imaging CT Request Form

Date: ____________________
yyyy / mm / dd

❒ 600 University Av. Toronto, Ont.
T • 416-586-4418
F • 416-586-3180

❒ TGH 585 University Av. Toronto, Ont.
❒ TWH 399 Bathurst St. Toronto, Ont.
❒ PM 610 University Av. Toronto, Ont.
T • 416-340-3384
F • 416-340-4661

❒ 76 Grenville St. Toronto. Ont.
T • 416-323-7515
F • 416-323-6316

PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL BE RETURNED

SURNAME	GIVEN NAME
BIRTHDATE: YYYY MM DD	HOSPITAL MEDICAL RECORD NO.

PATIENT EMAIL ADDRESS:

ADDRESS: (Street, Apt. #:)

CITY/TOWN PROVINCE POSTAL CODE

MOBILE PHONE NUMBER (preferred) (Area Code & Number)

( ) ________ - ____________________

Health Card Number Version Code

EXAMINATION(S)

Clinical History and Indications:

❒ **Routine** ❒ **Emergent** ❒ **Acute**

The following MUST be completed by the referring provider: (Please check)

1. Does the patient have a history of **Kidney disease?** Yes ❒ No ❒ **(eg. 1 kidney, renal failure, dialysis)**
2. Is the patient diabetic? Yes ❒ No ❒
3. Previous reaction to IV contrast? Yes ❒ No ❒
4. Does the patient have a pelvic/ileoanal pouch? Yes ❒ No ❒

If YES to question #1 or #2, please provide blood work (must be within the last 3 months)

Creatinine______ eGFR__________ Date: ___________

List Diabetic Medications:

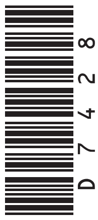
Known Allergies:

IF THE PATIENT HAS A KNOWN CONTRAST ALLERGY, THE REQUESTING PHYSICIAN IS RESPONSIBLE FOR ORGANIZING THE PRE-MEDICATION PRIOR TO THE PATIENTS SCAN, PLEASE FOLLOW THE PRE-MEDICATION INSTRUCTIONS BELOW:

PREDNISONE 50mg P.O 13 HOURS AND 1 HOUR PRE-EXAMINATION PLUS BENADRYL 50mg P.O 1 HOUR PRE-EXAMINATION.
NOTE: BENADRYL CAN CAUSE DROWSINESS, PATIENTS SHOULD MAKE ARRANGEMENTS TO BE DRIVEN TO AND FROM THE EXAMINATION.

Patient Weight: ____________kg/lbs.

Date of last LMP:________________
yyyy / mm / dd



Previous applicable surgery:_________________________ Relevant post-surgery & medical therapy ______________

REFERRING PROVIDER INFORMATION

Name and Initials (Print):	**Provider's Signature:** REQUIRED
Telephone #: ( )	**Fax #: ( )**
Requested Appointment Date (if applicable):	**Billing & CPSO #** REQUIRED
Provider's Address:	

CC report to: ____________________________

Interpreter required if **YES** what language: ______________