WCHH
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Tel: 416-323-7515
Fax: 416-323-6316

UHN
Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
Michener Institute

Tel: 416-340-3384
Fax: 416-340-4661

CARDIAC CT REQUISITION

Patient Information

Medical Record No.: _____ Health Card No.: _____ Version Code: _____

Name: _____ _____ DOB: _____/_____/_____ Sex: ❒ M ❒ F
First Name *Last Name* *day* *month* *year*

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

Home Tel.: _____ Cell: _____ Business Tel.: _____

Mobility Status: ❒ Walking ❒ Wheelchair ❒ Stretcher ❒ Ambulance Additional Info.: _____

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 REFERRING HEALTHCARE PROVIDER (REQUIRED) arrest, etc.): _____ _____
❒	❒	Does the patient require an interpreter? If **Yes**, what language? _____

Weight: _____

Height: _____

eGFR: _____

Clinical Information /Working Diagnosis:

_____

_____

_____

_____

Check below for expedited Cardiology referral in the event that CCTA is positive:

❒ Cardiac Link

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

Provider's Name:

_____ _____ _____
First name Last name Middle initial

Address: _____

City: _____ Postal Code: _____

Telephone: _____

Billing #: _____

Fax: _____ CPSO number: _____

IMPORTANT INSTRUCTIONS for Referring Provider

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.**

Provider's Signature: X _____ Date: _____ DD/MM/YYYY

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