London Health Sciences Centre

CT REQUISITION

University Hospital Bookings
Telephone: 519-663-3212
Fax: 519-663-3034

Victoria Hospital Central Bookings
Telephone: 519-685-8770
Fax: 519-667-6826

PATIENT INFORMATION: (Plate)

Name: _____

PIN#: _____

DOB: _____

HC#: _____

Address: _____

Phone: _____

PHYSICIAN INFORMATION:

Print Name (with initials): _____

Signature: _____

Address: _____

_____

Telephone: _____ Fax: _____

☐ INPATIENT ☐ OUTPATIENT

WSIB:

Claim Number: _____

Date of Injury: _____

Employer Address: _____

_____

_____

☐ 3rd PARTY / INSURANCE

EXAMINATION REQUESTED: _____

Clinical Problem: (must be entered) _____

_____

_____

All of the following questions must be completed before the CT will be booked.

1. (a) Does the patient have a history of impaired renal function, or are they currently on dialysis? ☐ Yes ☐ No
   (b) Does the patient have hypertension? ☐ Yes ☐ No
   (c) Does the patient have diabetes or are they over 70 years of age? ☐ Yes ☐ No
   (d) Does the patient have a medical condition predisposing them to nephrotoxicity? ☐ Yes ☐ No
   Please list: _____

   If you answered yes to any of the items in Question 1 and your patient requires/or may require IV contrast, a recent creatinine and/or eGFR must be forwarded with the requisition.

   Creatinine: _____ **or eGFR:** _____ **Date** (YYYY/MM/DD)**:** _____
2. Is the patient on any diabetes medications containing Metformin? ☐ Yes ☐ No
3. Is the patient allergic to radiographic IV contrast? ☐ Yes ☐ No
4. Patient's weight: _____ lb/kg
5. Has patient had any previous exams relevant to this study? ☐ Yes ☐ No
   If yes, what and where: _____
6. **Are you requesting a timed follow-up procedure (eg. 6 month follow-up)?**

   If yes, date requested (YYYY/MM/DD): _____

CT Exam Date (YYYY/MM/DD)**:** _____

-- RADIOLOGY USE ONLY --

Booking Priority:

- ☐ **1** Emergency <12 hour
- ☐ **2** Urgent
- ☐ **2T** Urgent/Timed
- ☐ **3** Semi Urgent
- ☐ **3T** Semi Urgent/Timed
- ☐ **4** Non Urgent
- ☐ **4T** Non Urgent/Timed

Protocol:

- ☐ **IV**
- ☐ **Oral**
- ☐ **Rectal**
- ☐ **NPO**