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:_____

WSIB:
Claim Number:_____
Date of Injury:_____
Employer address:_____
_____

☐ INPATIENT ☐ OUTPATIENT ☐ 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. Is the patient allergic to radiographic IV contrast? ☐ Yes ☐ No
2. (a) Is there a history of renal impairment or nephrectomy? ☐ Yes ☐ No
   (b) Is the patient currently on dialysis? ☐ Yes ☐ No
   (c) Is the patient over 70 years old? ☐ Yes ☐ No
   (d) Is the patient on any medication for diabetes? ☐ Yes ☐ No
   If yes, do they take medication called Metformin, Glucophage or Avandamet? ☐ Yes ☐ No
   (e) Does the patient have other medical conditions or take any medications that may predispose to nephrotoxicity? ☐ Yes ☐ No

   Please list: _____

   If you answered yes to any of the items in Question 2 and your patient requires/or may require IV contrast, a recent creatinine (<2 months) must be forwarded with the requisition.
   Creatinine: _____ **Date (YYYY/MM/DD):** _____
3. Given the patients history and as advised in the product monograph for Omnipaque 300, would you recommend the use of contrast if required? ☐ Yes ☐ No
4. Patient weight: _____lb/kg?
5. Is there a history of pheochromocytoma, multiples myeloma, heart disease or other?

   Please list:_____
6. **Are you requesting a timed follow-up procedure (eg. 6 month follow-up)?**

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

   If no, how would you rate the urgency or relative priority of this patient: (circle one)

   10 9 8 7 6 5 4 3 2 1
   Not Urgent At All — Extremely Urgent

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

-- RADIOLOGY USE ONLY--

Booking Priority:
- ☐ **1** Emergency <12 hr
- ☐ **2** Urgent
- ☐ **2T** Urgent/Timed
- ☐ **3** Semi Urgent
- ☐ **3T** Semi Urgent/Timed
- ☐ **4** Non Urgent
- ☐ **4T** Non Urgent/Timed

Protocol:
- ☐ **IV**
- ☐ **Oral**
- ☐ **Rectal**
- ☐ **NPO**