Peterborough Regional Health Centre Diagnostic Imaging Services

C.T. REQUISITION

Outpatient Booking: Fax 705-876-5046 Inpatient Booking: Fax 705-876-5127





inpution Booking ax 700 070 0121		
☐ Inpatient ☐ Outpatient	Patient Data (Print or place imprint upper right corner)	
☐ Ambulatory ☐ Non Ambulatory	Last Name:	
Hospital:	First Name:	
Transportation: Ambulance Car	Sex: ☐ Male ☐ Female Address:	
Physician Data:		Postal Code:
Name:	City: Phone:	DOB (dd/mm/yyyy)
Phone: Billing #:	Health Card #:	DOB (dd/mm/yyyy)
Report to: Dr: ; Dr: ; Dr: ; Dr: Within 24 hours 24-48 Hours 3-10 Days Elective		
	☐ 3-10 Days ☐ Elective	e
Area(s) to be scanned:		
		5
History/Clinical Information (relevant to exam requested):		~
This tory/offinical information (relevant to exam requested).		
March 1		
Previous related Imaging: No Yes If yes, where:		
→ INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED ←		
Blood work is required and must be included with CT request for patients with ANY of the following: Known Renal Dysfunction If Yes, explain: Diabetes Mellitus Age (over 70 yrs.) Multiple Myeloma Oncology Patient On Metformin/metformin containing drug Solitary Kidney PATIENT DOES NOT HAVE ANY ABOVE RISK FACTORS CREATININE (u mol/L) *eGFR (ml/min) PATIENT WEIGHT: Date Drawn: (dd/mm/yyyy) (Outpatients required bloodwork within 60 days of exam date)		
Previous Adverse Reaction to Contrast (x-ray dye)? No Yes		
If yes, explain Possibility of Pregnancy: □ No □ Yes Is patient able to give informed consent? □ No □ Yes If no, please have POA accompany patient.		
	Date:	1 7 1
Ordering Physician signature:	Date.	
Priority: 1 2 3 4		
Radiologist Coding Area:	Received:	
	Booked:	
(Staging/Dx)(Breast)(Other)	Notified:	