Orillia Soldiers' Memorial Hospital
170 Colborne St. West, Orillia, ON L3V 2Z3 Tel: **705-327-9127** Fax: **705-330-3224**

Request for CT Examination

(By Appointment Only)

PATIENT INFORMATION	**MRN No.**	**APPOINTMENT DATE:**	**TIME:**
☐ **IN-PATIENT** ☐ **OUT-PATIENT** ☐ **ER**			**ARRIVAL TIME:**

Last Name		**First Name**		
Date of Birth (d/m/y)	☐ **M** ☐ **F**	**Health Card No.**	**WSIB No.**	**3rd Party Ins. No.**
Address				
City	**Postal Code**	**Contact Number**	☐ **OK to leave voice mail message**	

Examination

- ☐ HEAD
- ☐ NECK
- ☐ C-SPINE
- ☐ CHEST
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ EXTREMITY: _____
- ☐ VIRTUAL COLONOSCOPY
- ☐ ENTEROGRAPHY
- ☐ STROKE
- ☐ SPINE: LEVEL _____
- ☐ OTHER _____

RELEVANT CLINICAL HISTORY:

IF THIS SECTION IS NOT COMPLETE, REQUISITION WILL BE RETURNED TO THE ATTENDING PHYSICIAN.

1. IS THE PATIENT ABLE TO GIVE CONSENT? ☐ YES ☐ NO If NO, please provide signed consent form.
2. ARE THERE ANY CONTRAINDICATIONS TO IV CONTRAST? (i.e. allergy, Metformin, renal/heart disease

3. (a) RENAL FUNCTION ASSESSMENT (please check appropriate box)

☐ Hx of Renal Disease ☐ Chemotherapy ☐ Hypertension ☐ Cirrhosis ☐ On Dialysis
☐ Vascular Disease ☐ Over 70 years ☐ Stroke ☐ Gout ☐ Diabetes

(b) If YES to any of the above, we require a current creatinine/eGFR in the last 6 months.

CREATININE LEVEL: CR _____ **eGFR** _____ **DATE:** _____

☐ Patient has NONE of the risk factors

FOR DEPARTMENT USE ONLY

EXAMINATION/ SPECIAL INSTRUCTIONS:

PRIORITY: ☐ P1 ☐ P2 ☐ P3 ☐ P4

Radiologist Signature:

PHYSICIAN INFORMATION

Physician's Name (Please PRINT clearly)		OFFICE STAMP:
Address/ Phone	**CPSO#**	
Physician's Signature X		

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.