Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

Tel: **705-327-9127** Fax: **705-330-3224**

REQUEST FOR

CT Examination

• BY APPOINTMENT ONLY •

PATIENT INFORMATION	MRN N°.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**
Last Name		First Name	☐ M ☐ F
Date of Birth (D/M/Y)	Health Card N°.	WSIB N°.	3rd Party Ins. N°.
Address	City		Postal Code
Email Address	Contact Number	■ OK to leave voice mail message	

Patient is able to give consent for this procedure: ☐ Yes ☐ No

Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ **SDM Name:** ☐ **SDM Contact Information:**

☐ **Patient requires assistance to complete this imaging exam,** *e.g. mobility, translation* **Please Specify:**

Examination

- ☐ HEAD
- ☐ NECK
- ☐ C-SPINE
- ☐ CHEST
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ EXTREMITY: _____
- ☐ VIRTUAL COLONOSCOPY
  Must be ordered by a surgeon.
- ☐ ENTEROGRAPHY
- ☐ STROKE

  SPINE: LEVEL _____

CLINICAL DATA/ DIAGNOSIS:

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

1. ARE THERE ANY CONTRAINDICATIONS TO IV CONTRAST? (i.e. allergy, Metformin, renal/heart disease)

2. **(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's Name
(Please PRINT clearly)

Phone **CPSO#**

Physician's Signature

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