Soldiers' MEMORIAL HOSPITAL Orillia

REQUEST FOR
CT Examination
• BY APPOINTMENT ONLY •

Tel: **705-327-9127** Out-Patient Fax: **705-330-3224** In-Patient Fax: **705-325-0582**

PATIENT INFORMATION

MRN N0. | Isolation Status

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ED ☐ AHF

Last Name	First Name		☐ M ☐ F
Date of Birth (D/M/Y)	Health Card N0.	WSIB N0.	3rd Party Ins. N0.
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
- ☐ OTHER:
- ☐ EXTREMITY:
- ☐ VIRTUAL COLONOSCOPY
  Must be ordered by a surgeon
- ☐ ENTEROGRAPHY
- ☐ STROKE
- ☐ SPINE: LEVEL _____

CLINICAL QUESTION AND RELEVANT CLINICAL INFORMATION
(Must be provided and must be specific)

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

1. ARE THERE ANY CONTRAINDICATIONS TO IV CONTRAST? (ie. 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

Physician's Name (Please PRINT clearly)	**Phone #**	**CPSO #**
Address	**Fax #**	Physician's Signature

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

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