



HOSPITAL ID:

OUTPATIENT CT REQUISITION FORM

PATIENT INFORMATION									
SURNAME				FIRST NAME				MIDDLE INITIAL	
ADDRESS						CITY		PROVINCE	POSTAL CODE
MOBILE PHONE #			ALTERNATE PHONE #		EMAIL				
Patient consents to appointment information being disclosed to them via text or e-mail						☐ Yes, text		☐ Yes, e-mail	
SEX ASSIGNED AT BIRTH		GENDER IDENTITY			DOB (YYYY/MM/DD)		HEIGHT(CM)		WEIGHT (KG)
☐ Female ☐ Male		☐ Female ☐ Male ☐ Other							
HEALTH CARD NUMBER (HN)				VERSION CODE (VC)		WSIB CLAIM #		OTHER (self-pay, research, 3rd party payor)	
☐ INTERPRETER REQUIRED Preferred language				ACCESSIBILITY CONCERNS OR REQUIREMENTS					
ALTERNATE CONTACT (IF NOT PATIENT)		CONTACT NAME				CONTACT PHONE #			
EXAM INFORMATION AND HISTORY									
TEST/REGION(S) TO BE EXAMINED ☐ Head ☐ Brain ☐ Sinuses ☐ Facial Bones ☐ Temporal Bones ☐ Orbits ☐ Circle of Willis ☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacral/Coccyx ☐ Thorax ☐ Routine ☐ High-resolution ☐ Pulmonary Embolism ☐ Thorax/Abdomen /Pelvis ☐ Abdomen/Pelvis ☐ Routine ☐ Renal Colic ☐ Urography ☐ Enterography ☐ Musculoskeletal (please indicate) ☐ OTHER EXAM TYPE (please indicate)					REASON FOR EXAM /CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable) <i>If the patient requires emergent attention, do not submit this form to Central Intake. Please contact your nearest imaging facility directly</i>				
SCREENING & PRECAUTIONS									
RENAL ASSESSMENT ☐ No known kidney issues ☐ Yes, patient has kidney problems, kidney transplant or is seeing a urologist If yes, check all that apply: ☐ Has diabetes ☐ On dialysis Please provide the most recent eGFR results (within the last 6 months) eGFR RESULT (ml/min/1.73²) DATE COLLECTED (YYYY/MM/DD)					☐ Known hypersensitivity to contrast agents ☐ Currently pregnant ☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable ☐ Requires general anesthesia Rationale <i>For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.</i>				
PREFERRED LOCATION									
All patients will be triaged to the shortest distance unless a preferred location is entered.					PREFERRED LOCATION(S)				
OTHER ROUTING CONSIDERATIONS									
REFERRING PROVIDER									
PROVIDER NAME					BILLING #			PROFESSIONAL ID	
ADDRESS					CITY		PROVINCE.	POSTAL CODE	
PHONE #			FAX #		COPY TO				
PROVIDER SIGNATURE							DATE		
OFFICE USE ONLY									
PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4				TIMED ☐ Yes ☐ No			SPECIFIED DATE		
OH ☐ Cancer ☐ No		PROTOCOL				RADIOLOGIST			