

CT REQUISITION – this form can be found on www.swpca Check one Site:

☐ Alexandra Marine and General Hospital-Goderich	F: 519-524-8532	☐ Middlesex Hospital Alliance - Strathroy	F: 519-246-5930
☐ Grey Bruce Health Services - Owen Sound	F: 519-376-3952	☐ South Bruce Grey Health Centre -Walkerton	F: 519-881-1388
☐ Hanover and District Hospital	F: 519-364-0062	☐ St. Joseph's Health Care London	F: 519-646-6204
☐ Huron Perth Health Care Alliance - Stratford	F: 519-272-8247	☐ St. Thomas Elgin General Hospital	F: 519-631-8842
☐ Listowel Memorial Hospital	F: 519-291-2813	☐ Tillsonburg District Memorial Hospital	F: 519-842-4299
☐ LHSC - UH	F: 519-663-3034	☐ Woodstock Hospital	F: 519-421-4238
☐ LHSC - VH /Children's	F: 519-667-6826		

PATIENT INFORMATION:

Surname: _____ First Name: _____ Middle Initial: _____
 Gender: ☐ M ☐ F ☐ X Date of Birth (YYYY-MM-DD): _____
 Street Address: _____ Apt: _____ City: _____ Province: _____ Postal Code: _____
 Health Card No.: _____ Version Code: _____ Research or 3rd Party No.: _____
 Telephone (Day): _____ (Evening): _____ (Cell): _____
☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ ED
 WSIB: ☐ Y ☐ N WSIB No.: _____ Date of Injury (YYYY-MM-DD): _____
 Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ☐ EN ☐ OTHER _____
 Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric ☐ Interpreter Required

Y N Please check the following:

- ☐ Allergic to radiographic contrast
☐ Pregnant _____ wks.
☐ Heparin Flush Ordered
☐ Power PICC
☐ CT Porta Cath
☐ History of Cancer

Precautions

- ☐ TB ☐ MRSA
☐ VRE ☐ Shingles

** If yes to any of the risk factors please draw creatinine levels

Y N Contrast Risk Factors:

- ☐ Diabetic
☐ On dialysis
☐ History of impaired renal function or Nephrectomy
☐ Patient > 70 yrs old
☐ On any diabetic medications: _____
☐ Hypertension
☐ Medications/conditions predisposing to nephrotoxicity
☐ Other: _____

- ☐ Y ☐ N Related surgery

- ☐ Y ☐ N Urgent

- ☐ Y ☐ N Routine

- ☐ Y ☐ N Timed _____

- ☐ Y ☐ N Cancer

- ☐ Y ☐ N Staging/ Followup

Timing of above

Please attach previous imaging and reports (ie ECG)

REFERRING PHYSICIAN:

Name: _____ Address: _____
 City: _____ Postal Code: _____ Tel: _____ FAX: _____
 Physician's Signature: _____ CPSO No: _____
 Copy to: _____

Serum Creatinine (must be drawn within the past 3 months)

Result: _____

eGFR: _____

Sample date: _____

Height: cm/in. _____

Weight: kg/lbs. _____

EXAMINATION REQUESTED:

WORKING DIAGNOSIS:

CLINICAL INFORMATION:

OFFICE USE ONLY

Protocol:

- ☐ Water Prep ☐ Barium ☐ Water Soluble ☐ Enterography Prep
☐ IV ☐ Rectal ☐ Non Contrast ☐ without and check
☐ Nitro ☐ Beta Blockers ☐ Hyoscine (Buscopan)
☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed: _____
 Staff Initials: _____

FOR TECHS/RADS

FOR BOOKING STAFF

Appointment Date:

Arrival Time:

NOTE: This requisition may be booked at an alternate site in the South West LHIN to improve patient access.