HDH HANOVER & DISTRICT HOSPITAL

CT REQUISITION

Date: _____ ❒ Inpatient ❒ER Patient
Patient's Name: _____
Date of Birth: _____ (YYYY/MM/DD)
Ordering Physician: _____
Fax Appointment & Report to: _____

Hospital: _____
Health Card: _____
Telephone: _____
Telephone: _____

Study Required: CT of _____
Clinical Data/ Provisional Diagnosis _____
_____

Referring Physician to Complete & Sign:

1. Does the patient have a history of impaired renal function, or are they currently on Dialysis? ❒ Yes ❒ No
2. Does the patient have hypertension? ❒ Yes ❒ No
3. Does the patient have diabetes or are they over 70 years of age? ❒ Yes ❒ No
4. Does the patient have a medical condition predisposing them to nephrotoxicity? ❒ Yes ❒ No

If you answered yes to any of Questions 1 to 4 and your patient requires/may require IV contrast, a recent creatinine (<3 months) must be forwarded with this requisition.

Creatinine: _____ Date: _____

5. Is the patient on diabetes medications call Metformin, Glucophage or Avandamet? ❒ Yes ❒ No
6. Is the patient allergic to radiographic IV contrast? ❒ Yes ❒ No
7. Patient's Weight: _____ lbs/ kgs
8. Has the patient had any previous exams relevant to this study? ❒ Yes ❒ No
9. Are you requesting a timed follow- up procedures (eg. 6 month follow up)? ❒ Yes ❒ No
   If yes, date requested: _____

❒ Inpatient
❒ Emergency Patient
❒ Outpatient/ Emergency as Outpatient
❒ Cancer Staging/ Re-staging

Physician Signature: _____

*** COMPLETION OF ABOVE INFORMATION IS MANDATORY BEFORE APPOINTMENT CAN BE MADE***

Radiologist Use:

Contrast
❒ Oral
❒ IV
❒ With and Without
❒ Without
❒ Without and Check

Protocol: _____

Notes: _____
_____
_____

Priority Level
❒ 1
❒ 2
❒ 3 ❒ T3
❒ 4 ❒ T4

Hydration Recommended
❒ Pre ❒ Post

Clinical Indication
❒ Cancer Staging and/or Diagnosis
❒ Other
❒ Breast Cancer Screening

Radiologist's Signature: _____

Appointment Date/Time: _____

Reg Received: _____ Scan Start: _____ Scan Comp: _____ Report Final: _____