

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

- | | | | |
|---|-----------------|--|-----------------|
| <input type="checkbox"/> Alexandra Marine and General Hospital-Goderich | F: 519-524-8532 | <input type="checkbox"/> Middlesex Hospital Alliance - Strathroy | F: 519-246-5930 |
| <input type="checkbox"/> Grey Bruce Health Services - Owen Sound | F: 519-376-3952 | <input type="checkbox"/> South Bruce Grey Health Centre -Walkerton | F: 519-881-1388 |
| <input type="checkbox"/> Hanover and District Hospital | F: 519-364-0062 | <input type="checkbox"/> St. Joseph's Health Care London | F: 519-646-6204 |
| <input type="checkbox"/> Huron Perth Health Care Alliance - Stratford | F: 519-272-8247 | <input type="checkbox"/> St. Thomas Elgin General Hospital | F: 519-631-8842 |
| <input type="checkbox"/> Listowel Memorial Hospital | F: 519-291-2813 | <input type="checkbox"/> Tillsonburg District Memorial Hospital | F: 519-842-4299 |
| <input type="checkbox"/> LHSC - UH | F: 519-663-3034 | <input type="checkbox"/> Woodstock Hospital | F: 519-421-4238 |
| <input type="checkbox"/> 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: _____ Billing No: _____

Copy to: _____ Date: _____

Serum Creatinine (must be drawn within the past 6 months)

Result: _____

eGFR: _____

Sample date: _____

Height: cm/in. _____

Weight: kg/lbs. _____

EXAMINATION REQUESTED:

WORKING DIAGNOSIS:

CLINICAL INFORMATION:

FOR BOOKING STAFF

Prep Information

- No prep required
 Clear fluids only 4 hours prior
 Drink 1 bottle of water en route & do not void
 Patient may be here 2+ hours
 Bring list of medications
 Start IV # _____
 Consent obtained by MRP

Appointment Date:

Arrival Time:

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

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