

Request for CT Scan

Humber River Hospital
 1235 Wilson Ave. **LEVEL 2 EAST**
 Toronto, ON M3M 0B2

Phone 416-242-1000 Ext. 63311 **Fax** 416-242-1078



Appointment Information

Date _____ Time _____

Patient Information

Name _____
 OHIP # _____ VC _____
 DOB (d/m/y) _____ Sex M F
 Address _____
 City _____ PC _____
 Phone _____

Area to be Scanned

Clinical Information

Does Your Patient Have Any of the Following Risk Factors for Contrast Administration? (Must be Completed)

Does your patient have kidney disease or a kidney transplant?	<input type="checkbox"/> Y <input type="checkbox"/> N	A serum creatinine value must be provided if you have answered Yes to any of the risk assessment questions. The blood collection date must be within 180 days of the appointment date. _____ Creatinine (µmol/L) _____ EGFR (mL/min/1.73 m ²) _____ Blood Collection Date (d/m/y) Missing blood test(s) may be ordered on your behalf.
OR	<input type="checkbox"/> Y <input type="checkbox"/> N	
Is your patient currently seeing, or waiting to see a kidney specialist, urologist (kidney surgeon)?	<input type="checkbox"/> Y <input type="checkbox"/> N	

Y N Allergy to Iodine Contrast Material? If Yes, describe reaction: _____

If your patient has had any previous severe reaction to X-Ray contrast material, you the referring provider, must prescribe the following recommended premedication treatment (from the ACR Manual on Contrast Media), Patients must arrange to be driven to and from this appointment as diphenhydramine may cause drowsiness (this is not a prescription).

- 50 mg prednisone PO at 13, 7, and 1 hour before contrast material administration
- 50 mg diphenhydramine PO 1 hours before contrast material administration

Y N Other Allergies _____

Y N Pregnant, Breastfeeding

REPORTS FROM RELEVANT PRIOR EXAMINATIONS MUST BE INCLUDED WITH THIS REFERRAL FORM.

IF YOUR PATIENT IS NOT ENGLISH SPEAKING, PLEASE ASK THEM TO HAVE AN INTERPRETER ACCOMPANY THEM TO THEIR APPOINTMENT.

Referring Doctor Information

Name (PRINT) _____
 Address _____
 City _____ PC _____
 Phone _____ Fax _____
Signature _____
 CPSO # _____ Billing # _____

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITION FORMS WILL BE RETURNED

Form # 002206, version (02-2023)

