Request for CT Scan

Wilson Avenue Site
1235 Wilson Avenue, 2nd Floor
Toronto, ON M3M 0B2
Tel. (416) 242-1000 ext. 63311
Fax (416) 242-1078

Appointment Information

Department Use Only
Appointment Location WILSON SITE

Appointment Date (d/m/y) ____________________

Appointment Time ____________________

❑ No preparation is required. Arrive 30 minutes before the Appointment Time

❑ Nothing by mouth 2 hours before the exam. Arrive 30 minutes before the Appointment Time

❑ Nothing by mouth 4 hours before the exam. Arrive 90 minutes before the Appointment Time

Patient Information

Health Card No. ____________________

Last Name ____________________

First Name ____________________

❑ M ❑ F

Date of Birth (d/m/y) ____________________

Address ____________________

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Home Phone ____________________

Other Phone ____________________

Patient History

Requesting CT Scan of the Following Area(s)

Height (cm) __________ Weight (kg) __________

Allergies ____________________

Creatinine < 90 days ____________________

Risks for Contrast Administration*

❑ Diabetic
❑ Using medication containing Metformin
❑ Cardiovascular and/or respiratory disease (eg., Hypertension, Asthma)
❑ Cancer (especially Myeloma, Pheochromocytoma)
❑ Kidney dysfunction and/or solitary kidney
❑ Sickle-cell Disease or Polycythemia
❑ Pregnant or breastfeeding
❑ Hypotensive (< 90/60 mm Hg)

*If your patient has an allergy to X-ray/CT contrast material, or has had a previous **severe** reaction to X-ray/CT contrast material, you **must** prescribe the standard oral premedication treatment for X-ray/CT contrast material allergy.

Clinical Indication for Exam ____________________

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Physician Information

Physician's Name (Please PRINT) ____________________

Address ____________________

____

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Phone ____________________

Fax ____________________

Physician's Signature × ____________________

Department Use Only
Priority
❑ 1. Emergent ❑ 2. Inpatient/Urgent
❑ 3. Cancer Staging ❑ 4. Semi/Non-urgent
❑ Timed Procedure/Wait Times Specified

Clinical Indication
❑ BC Breast Cancer Screening
❑ SD Cancer Staging and/or Diagnosis
❑ OT Other

Coding ____________________

Radiologist's Signature × ____________________

INCOMPLETE, ILLEGIBLE, AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED

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