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

Humber River Hospital

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**)

☐ Y ☐ N Pregnant, Breastfeeding
☐ Y ☐ N Diabetic
☐ Y ☐ N Using Metformin
☐ Y ☐ N Acute or Chronic Kidney Disease
☐ Y ☐ N On Hemodialysis
☐ Y ☐ N Kidney Surgery, Kidney Transplant
☐ Y ☐ N Single Kidney
☐ Y ☐ N Hypertension
☐ Y ☐ N Other Cardiovascular Disease
☐ Y ☐ N Respiratory Disease
☐ Y ☐ N Gout
☐ Y ☐ N Sickle Cell Disease, Polycythemia
☐ Y ☐ N Cancer (Especially Myeloma, Renal/Adrenal Cancer)

A serum Creatinine value must be provided if you have answered Yes to any of these risk assessment questions. The blood collection date must be within 90 days of the appointment date.

Creatinine _____ µmol/L

Blood Collection Date (d/m/y) _____

☐ Y ☐ N Previous Contrast Reaction

☐ Y ☐ N Other Allergies _____

_____

If your patient has had any previous adverse 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.

℞

1. 50 mg Prednisone PO at 13, 7, and 1 hour before contrast material administration
2. 50 mg Diphenhydramine PO 1 hour before contrast material administration

Height _____ cm **Weight** _____ kg

Table weight limit is 295 kg/650 lbs

Referring Doctor Information	***Department Use Only***
Name (PRINT) _____	Priority ☐ P1 ☐ P2 ☐ P3 ☐ P4
Address _____	Clinical Indication ☐ OT ☐ SD ☐ Timed
City _____ PC _____	Radiologist Code _____
Phone _____ Fax _____	Radiologist Signature _____
Signature _____	MRT Code _____
CPSO # _____ Billing # _____	MRT Signature _____

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

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