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)

Age > 60 Years ☐ Y ☐ 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 90 days of the appointment date.
Chronic Kidney Disease ☐ Y ☐ N	
On Dialysis ☐ Y ☐ N	
Acute renal Disease ☐ Y ☐ N	
Renal Cancer ☐ Y ☐ N	
Renal Surgery ☐ Y ☐ N	
Renal Transplant ☐ Y ☐ N	_____ Creatinine (µmol/L)
Single Kidney ☐ Y ☐ N	
Diabetes ☐ Y ☐ N	_____ EGFR (mL/min/1.73 m^2)
On Metformin Containing Medications ☐ Y ☐ N	
Vascular Disease (Hypertension) ☐ Y ☐ N	_____ Blood Collection Date (d/m/y)
Gout ☐ Y ☐ N	
Proteinuria ☐ Y ☐ N	Missing blood test(s) may be ordered on your behalf.
NONE OF THE ABOVE ☐ Y	

☐ 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).

1. 50 mg prednisone PO at 13, 7, and 1 hour before contrast material administration
2. 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 (12-2021)

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