Request for CT Scan

Humber River Hospital
1235 Wilson Ave. **LEVEL 2 EAST**
Toronto, ON M3M 0B2
Phone 416-242-1000 Ext. 63311 ***Fax*** 1-855-509-0213

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
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
Single Kidney	☐ Y ☐ N
Diabetes	☐ Y ☐ N
On Metformin Containing Medications	☐ Y ☐ N
Vascular Disease (Hypertension)	☐ Y ☐ N
Gout	☐ Y ☐ N
Proteinuria	☐ Y ☐ N
NONE OF THE ABOVE	☐ Y

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.

_____ 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.

☐ 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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