

*This form is for physician use only.*

# Request for CT

## PATIENT INFORMATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex  F  M  Other  
Last name, First name Year-Month-Day

Health card \_\_\_\_\_ Version code \_\_\_\_\_ Schroeder MRN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Postal code \_\_\_\_\_ Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_  
Preferred Alternate

## TEST/REGION TO BE EXAMINED

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Head           | <input type="checkbox"/> HRCT Chest             | <input type="checkbox"/> CTA Carotids   |
| <input type="checkbox"/> Neck           | <input type="checkbox"/> CT Urogram (triphasic) | <input type="checkbox"/> Sinuses        |
| <input type="checkbox"/> Chest          | <input type="checkbox"/> CT Enterogram          | <input type="checkbox"/> Facial Bones   |
| <input type="checkbox"/> Abdomen/Pelvis | <input type="checkbox"/> Renal Colic            | <input type="checkbox"/> Temporal Bones |

Other: \_\_\_\_\_

## SCREENING

### NEPHROPATHY

- Chronic kidney disease.....  Y  N
- Prior acute kidney injury.....  Y  N
- Kidney surgery, ablation, transplant, cancer.....  Y  N
- Albuminuria.....  Y  N
- Dialysis.....  Y  N
- If any nephropathy risk factor, provide:*

eGFR \_\_\_\_\_ Test date (< 3 months) \_\_\_\_\_  
Year-Month-Day

## CLINICAL INDICATION/RELEVANT HISTORY

Relevant previous imaging reports must be attached

## PRECAUTIONS

- Patient weight..... \_\_\_\_\_ kg
- Chance of pregnancy.....  Y  N
- Allergy to IV contrast.....  Y  N

## BILLING

OHIP \_\_\_\_\_  WSIB claim # \_\_\_\_\_  Other \_\_\_\_\_

## REFERRING PHYSICIAN

*Name, address, fax, phone, billing number:*

Physician Name

Physician Address

Phone

Fax

Physician Billing Number

Send copies to:

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_