STEVENSON MEMORIAL HOSPITAL

200 Fletcher Crescent, Alliston, Ontario L9R 1W7

add checkboxes for “patient notified” “DART done” “Faxed to Office” “Prep Explained”

TO BOOK AN APPOINTMENT:
Phone: 705-434-5133
Fax: 705-434-5111

Please bring a copy of the requisition with you to your appointment

APPOINTMENT DATE AND TIME: _____

CT SCAN REQUISITION

Patient Name: PRINT CLEARLY OR USE PATIENT LABEL	**Health Card #:**
Address:	
Phone #:	**DOB: (YY/MM/DD)**

HOSPITAL USE ONLY Wait 2 System Delay

☐ Emergency Closures ☐ Lack of Hospital Resources ☐ Patient Preference ☐ Prerequisites Not Met ☐ Reschedule due to Higher Priority Case

Dates Affecting Readiness to Treat (Enter Dates):_____

Dates Affecting Readiness to Treat Reason: ☐ Developmentally Appropriate Wait* ☐ Inability to Contact Patient
☐ Change in Medical Status ☐ Missed Procedure ☐ Neo-Adjuvant Chemotherapy
☐ Neo-Adjuvant Radiation Therapy ☐ Patient chooses to defer

* Applicable only to Pediatric Procedures

Previous contrast Reaction: ☐ Yes ☐ No If Yes, When and What:_____

Is the Patient Diabetic?: ☐ Yes ☐ No On Metformin? ☐ Yes ☐ No –* ***If yes, do not take Metformin on day of exam***

Glucophage ☐ Insulin ☐ Does the Patient have a solitary Kidney? ☐ Yes ☐ No Is there Renal Insufficiency? ☐ Yes ☐ No

Creatinine Level Required for Yes Answers including over 60 yrs of age: **if 60 yrs or older check box** ☐

(yyyy/mm/dd) _____/_____/_____ Level: (within last 6 months)

_____

AREA TO BE SCANNED: *(check box)*

☐ Head	☐ Sinuses	☐ C-Spine	☐ Chest	☐ Neck	☐ Other
☐ Facial Bones	☐ Mastoids/Temporal Bones	☐ T-Spine	☐ Abdomen	☐ Renal Stone Protocol	*(please specify)*
☐ Orbits	☐ Sella	☐ L-Spine	☐ Pelvis	☐Extremity ☐R or ☐L	_____

Relevant Clinical Information *(Must be provided):*_____

_____

Clinical Indication for Scan: ☐ Cancer Staging and/or Diagnosis ☐ Breast Cancer Screening ☐ Other _____

RADIOLOGIST USE ONLY

	Without Contrast	With Contrast	Without/ With Contrast
HEAD	☐	☐	☐
NECK	☐	☐	☐
SPINE	☐	☐	☐
THORAX	☐	☐	☐
ABDOMEN	☐	☐	☐
PELVIS	☐	☐	☐
EXTREMITY	☐	☐	☐
OTHER	☐	☐	☐

☐ Oral Contrast

☐ Rectal Contrast

Priority ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ T Specified Date Procedure:_____

Special Instructions:

_____
Radiologist Signature

CT SCAN CANNOT BE PERFORMED WITHOUT A REQUISITION SIGNED BY A PHYSICIAN

Referring Physician Printed Name, Phone and FAX and Signature:	**Date:** (yyyy/mm/dd)