200 Fletcher Crescent
Alliston, Ontario L9R 1W7
Tel: 705-435-6281

Patient Notified ________
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*

| **Name:** | **Health Card #:** |
|---|---|
| **Address:** | |
| **Phone #:** | **DOB:** (dd/mm/yy) |

| | Yes | No |
|---|---|---|
| 1. Is the Patient diabetic? | ☐ | ☐ |
| 2. Does the Patient have a solitary kidney? | ☐ | ☐ |
| 3. Is there Renal Insufficiency? | ☐ | ☐ |
| 4. Is the Patient 60 years old or greater? | ☐ | ☐ |
| 5. Has the Patient had a previous reaction to contrast? | ☐ | ☐ |
| eGFR or Creatinine level required if Yes to #1, 2, 3, or 4<br>Test date: _____/_____/_____ Level (within 3 months):_____________ | ☐ | ☐ |
| Weight: ___________ Is the Patient possibly pregnant? | ☐ | ☐ |

**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 _______________
☐ CTA, specify: ___________________________

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

__________________________________________________________________________________

**Clinical Indication for Scan:** ☐ Cancer Staging ☐ Cancer Surveillance ☐ Breast Cancer ☐ 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 (for Radiologist):**

_________________________
Radiologist Signature

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

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

H-CSR

SM0062-07 June 2022