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

TO BOOK AN APPOINTMENT:
Phone: 705-434-5133
Fax: 705-434-5111
Please bring a copy of the requisition with you to your appointment.

Patient Notified _____
Dart Done _____ Prep Explained _____ No Metformin _____

APPOINTMENT DATE AND TIME:_____

CT SCAN REQUISITION

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

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: **and if 60 yrs or older check box** ☐
(dd/mm/yy) _____/_____/_____ 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:** (dd/mm/yy)