Perth and Smiths Falls District Hospital

CT Requisition

CT Fax: 613-283-5371
CT Booking Clerk: 613-283-2330 ext. 2170

Ambulation: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Bed
Precautions: ☐ None ☐ Contact ☐ Droplet ☐ Airborne

INCOMPLETE or ILLEGIBLE requisitions will be returned and may DELAY the study

Health Card #: _____ **Location:** ☐ Outpatient ☐ Emergency ☐ Inpatient: _____

Surname: _____ Date of Birth: _____ ☐ Female ☐ Male

First Name: _____ Address: _____

Phone Number: _____ (Preferred) _____ (Alternative) Z#: _____

Note: CT Weight Limit - 500lbs (227kg)

Examination Requested: (Include relevant reports)	**Clinical History/Diagnosis:**

☐ **Patient does not have any of the risk factors for CIN. No bloodwork required.**

☐ **Patient has CIN risk factors as identified below:**

- Age > 70
- History of Hypertension Requiring Medical Therapy
- History of Diabetes Mellitus
- History of Renal Disease (includes dialysis, transplant, single kidney, renal cancer, renal surgery)

Bloodwork is required within 90 days (out-patients with CIN risk factors), 7 days (stable in-patients) or 24 hours (acutely ill patients)

Creatinine: _____µmol/L **eGFR:** _____mL/min **Date Drawn:** _____

Known Allergies: _____ LMP: _____

Physician Signature: _____ Print Name: _____

Billing Number: _____ Date Requisition Completed: _____

Copy Report To: _____

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Protocol:

IV:
- ☐ C-
- ☐ C+
- ☐ C- & C+

Oral:
- ☐ Water Based
- ☐ Water Only
- ☐ None

Signature of Radiologist:

☐ Pre-Medication **Priority:** 1☐ 2☐ 3☐ 4☐