



60 Cornelia Street West
Smiths Falls, ON K7A 2H9
(613) 283-2330 ext. 1419
(613) 283-5371 (fax)



Perth and Smiths Falls District Hospital – CT Department
Action Required: CT Contrast Induced Nephropathy (CIN) Screening Questionnaire

Date:

Health Care Provider:

Fax #:

You have requested a CT scan for your patient (Name) _____
DOB: _____ that will require an injection of IV iodinated
contrast. Patients with certain risk factors are at a higher risk of developing contrast induced
nephropathy.

For patient safety, the following information is required before your referral can be
processed:

1. Does your patient have known kidney problems or have they received a kidney
transplant?
 Yes
 No

2. Has your patient seen or are they waiting to see a nephrologist or urologist?
 Yes
 No

*If you answer yes to either of these questions, please provide a recent eGFR (within
6 months) along with this form

Provider Signature: _____

Please fax this completed form along with any eGFR results, if necessary, so we can
process this referral.

Thank you for your co-operation