Perth and Smiths Falls District Hospital

# CT Requisition

**CT Fax: 613-283-5371**
**CT Booking Clerk: 613-283-2330 ext. 1419**

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

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

*By submission of this requisition, your patient is authorizing PSFDH to contact them by phone, text, and/or email.*

Health Card #: _____ MRN#_____ **Note:** CT Weight Limit - 500lbs (227kg)
Surname: _____ Date of Birth: _____ ☐ Female ☐ Male ☐ Other
First Name: _____ Address: _____
Phone Number: _____ **Location:** ☐ Outpatient ☐ Emergency ☐ Inpatient Floor_____

**Examination Requested:** (Include relevant reports)

Contrast ☐ Non-contrast ☐

**Clinical History/Diagnosis:**

**The following information must be provided prior to test being scheduled:**

Is your patient pregnant? Yes ☐ No ☐ Allergy to Iodine? Yes ☐ No ☐

**Contrast Induced Nephropathy Screening: (Outpatients)**

Does your patient have kidney problems/impairment, solitary kidney or have they had a kidney transplant? Yes ☐ No☐

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

**If yes to any of the above questions, bloodwork IS required within 6 months:**
**eGFR:_____(mL/min) Date drawn:_____**

**Blood Work Requirements for ER & Inpatients: ER - 24 hours Inpatients – 7 days**
**eGFR:_____(mL/min) Date drawn:_____**

☐ ****Contrast required but eGFR is unavailable or eGFR is less than >30 mL/min**** The risk of allergy or contrast induced nephropathy has been discussed with the patient/POA and they are willing to proceed understanding the risks._____
**(MRP initials)**

Physician name(print):_____ Signature:_____

Billing number: _____ Date Requisition Completed:_____

Copy Report to:_____

**FOR IMAGING USE ONLY**

Protocol:

Signature of Radiologist:

IV:
☐ C-
☐ C+
☐ C- & C+
☐ Oral Contrast
☐ Pre-Medication

D1_____, _____, _____
D2_____, _____, _____
D3_____, _____, _____
TIMED Y N SYS DELAY Y N
**Priority:** 1☐ 2☐ 3☐ 4☐