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 #: _____ Z#_____ **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)

_____

Working Diagnosis:

Contrast ☐ Non-contrast ☐

Clinical History/Diagnosis:

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

☐ Age > 70 ☐ Acutely ill and/or dehydrated

☐ On nephrotoxic medications ☐ History of significant renal impairment/failure (eGFR known to be less than >30 mL/min)

Bloodwork IS required within six (6) months (out-patients with CIN risk factors), 7 days (stable in-patients), 24 hours (acutely ill patients)

Creatinine:_____(umol/L) eGFR:_____(mL/min) Date drawn:_____

☐ **Patient does not meet ANY of the above criteria and will NOT require bloodwork.**

☐ ***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)

Known Allergies: _____ Date Requisition Completed:_____

Physician name(print):_____ Sign Here:_____

Billing number: _____ Copy Report to:_____

FOR IMAGING USE ONLY

Protocol:

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

D1_____, _____, _____
D2_____, _____, _____
D3_____, _____, _____
TIMED Y N SYS DELAY Y N

Priority: 1 ☐ 2☐ 3☐ 4 ☐

Signature of Radiologist: