

OUTPATIENT CT REQUISITION FORM

PATIENT INFORMATION

SURNAME		FIRST NAME		MIDDLE INITIAL	
ADDRESS			CITY	PROVINCE	POSTAL CODE
MOBILE PHONE #	ALTERNATE PHONE #	EMAIL			
Patient consents to appointment information being disclosed to them via text or e-mail			<input type="checkbox"/> Yes, text	<input type="checkbox"/> Yes, e-mail	
SEX ASSIGNED AT BIRTH <input type="checkbox"/> Female <input type="checkbox"/> Male	GENDER IDENTITY <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		DOB (YYYY/MM/DD)	HEIGHT(CM)	WEIGHT (KG)
HEALTH CARD NUMBER (HN)	VERSION CODE (VC)	WSIB CLAIM #	OTHER (self-pay, research, 3rd party payor)		
<input type="checkbox"/> INTERPRETER REQUIRED Preferred language	ACCESSIBILITY CONCERNS OR REQUIREMENTS				
ALTERNATE CONTACT (IF NOT PATIENT)	CONTACT NAME		CONTACT PHONE #		

EXAM INFORMATION AND HISTORY

TEST/REGION(S) TO BE EXAMINED <input type="checkbox"/> Head <input type="checkbox"/> Brain <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Circle of Willis <input type="checkbox"/> Neck <input type="checkbox"/> Routine <input type="checkbox"/> Carotids <input type="checkbox"/> OTHER EXAM TYPE (please indicate)	REASON FOR EXAM /CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable) <input type="checkbox"/> Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral/Coccyx <input type="checkbox"/> Thorax <input type="checkbox"/> Routine <input type="checkbox"/> High-resolution <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Thorax/Abdomen /Pelvis <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Routine <input type="checkbox"/> Renal Colic <input type="checkbox"/> Urography <input type="checkbox"/> Enterography <input type="checkbox"/> Musculoskeletal (please indicate)
<i>If the patient requires emergent attention, do not submit this form to Central Intake. Please contact your nearest imaging facility directly</i>	
<input type="checkbox"/> TIMED FOLLOW UP DATE REQUESTED (YYYY/MM/DD) <i>CT availability is limited: requested dates will be accommodated where possible.</i>	

SCREENING & PRECAUTIONS

RENAL ASSESSMENT <input type="checkbox"/> No known kidney issues <input type="checkbox"/> Yes, patient has kidney problems, kidney transplant or is seeing a urologist If yes, check all that apply: <input type="checkbox"/> Has diabetes <input type="checkbox"/> On dialysis Please provide the most recent eGFR results (within the last 6 months) eGFR RESULT (ml/min/1.73 ²) DATE COLLECTED (YYYY/MM/DD)	<input type="checkbox"/> Known hypersensitivity to contrast agents <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Patient cannot provide reliable medical history or provide consent to contrast injections where applicable <input type="checkbox"/> Requires general anesthesia Rationale <i>For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.</i>
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PREFERRED LOCATION

All patients will be triaged to the shortest distance unless a preferred location is entered.	PREFERRED LOCATION(S)
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OTHER ROUTING CONSIDERATIONS

REFERRING PROVIDER

PROVIDER NAME		BILLING #		PROFESSIONAL ID
ADDRESS			CITY	PROVINCE. POSTAL CODE
PHONE #	FAX #	COPY TO		
PROVIDER SIGNATURE				DATE

OFFICE USE ONLY

PRIORITY <input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4	TIMED <input type="checkbox"/> Yes <input type="checkbox"/> No	SPECIFIED DATE
OH <input type="checkbox"/> Cancer <input type="checkbox"/> No	PROTOCOL	RADIOLOGIST