

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 (Choosing Wisely checklists MUST accompany referrals where appropriate i.e. Spine)	REASON FOR EXAM /CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)
<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)	<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 <input type="checkbox"/> 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)	<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 past 3-6 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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REFERRING PROVIDER

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

DEFAULT LOCATION - MUST BE SELECTED

Select the default hospital you would send this patient to, given their diagnostic imaging requirements:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alexandra Marine and General Hospital | <input type="checkbox"/> Guelph General Hospital | <input type="checkbox"/> London Health Sciences Centre | <input type="checkbox"/> Strathroy Middlesex General Hospital |
| <input type="checkbox"/> Bluewater Health | <input type="checkbox"/> Haldimand War Memorial Hospital | <input type="checkbox"/> Niagara Health System | <input type="checkbox"/> Tillsonburg District Memorial Hospital |
| <input type="checkbox"/> Brant Community Healthcare System | <input type="checkbox"/> Hamilton Health Sciences | <input type="checkbox"/> Norfolk General Hospital | <input type="checkbox"/> Waterloo Regional Health Network |
| <input type="checkbox"/> Brightshores Health System | <input type="checkbox"/> Hanover and District Hospital | <input type="checkbox"/> South Bruce Grey Health Centre | <input type="checkbox"/> Wellington Health Care Alliance |
| <input type="checkbox"/> Cambridge Memorial Hospital | <input type="checkbox"/> Huron Perth Healthcare Alliance | <input type="checkbox"/> St Joseph's Health Care - London | <input type="checkbox"/> Windsor Regional Hospital |
| <input type="checkbox"/> Chatham-Kent Health Alliance | <input type="checkbox"/> Joseph Brant Hospital | <input type="checkbox"/> St Joseph's Healthcare - Hamilton | <input type="checkbox"/> Woodstock Hospital |
| <input type="checkbox"/> Erie Shores Healthcare | <input type="checkbox"/> Listowel Wingham Hospital Alliance | <input type="checkbox"/> St Thomas-Elgin General Hospital | |

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
CCO <input type="checkbox"/> Cancer <input type="checkbox"/> No	PROTOCOL	RADIOLOGIST