

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		GENDER IDENTITY		DOB (YYYY/MM/DD)	HEIGHT (CM)
<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other			
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) <input type="checkbox"/> Head <ul style="list-style-type: none"> <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 <ul style="list-style-type: none"> <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 <ul style="list-style-type: none"> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral/Coccyx <input type="checkbox"/> Thorax <ul style="list-style-type: none"> <input type="checkbox"/> Routine <input type="checkbox"/> High-resolution <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Thorax/Abdomen /Pelvis <ul style="list-style-type: none"> <input type="checkbox"/> Abdomen/Pelvis <ul style="list-style-type: none"> <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 <ul style="list-style-type: none"> <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: <ul style="list-style-type: none"> <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>	

REFERRING PROVIDER

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

OFFICE USE ONLY

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