

# 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			Yes, Text	Yes, e-mail	
SEX ASSIGNED AT BIRTH	GENDER IDENTITY		DOB (YYYY/MM/DD)	HEIGHT(CM)	WEIGHT (KG)
<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

<b>TEST/REGION(S) TO BE EXAMINED (Choosing Wisely checklists MUST accompany referrals where appropriate i.e. Spine)</b>  <input type="checkbox"/> <b>Head</b> <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"/> <b>Neck</b> <input type="checkbox"/> Routine <input type="checkbox"/> Carotids  <input type="checkbox"/> <b>OTHER EXAM TYPE</b> (please indicate)	<input type="checkbox"/> <b>Spine</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral/Coccyx  <input type="checkbox"/> <b>Thorax</b> <input type="checkbox"/> Routine <input type="checkbox"/> High-resolution <input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> <b>Thorax/Abdomen /Pelvis</b> <input type="checkbox"/> <b>Abdomen/Pelvis</b> <input type="checkbox"/> Routine <input type="checkbox"/> Renal Colic <input type="checkbox"/> Urography <input type="checkbox"/> Enterography  <input type="checkbox"/> <b>Musculoskeletal</b> (please indicate)	<b>REASON FOR EXAM /CLINICAL HISTORY</b> (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)          <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"/> <b>TIMED FOLLOW UP</b> <b>DATE REQUESTED</b> (YYYY/MM/DD)  <i>CT availability is limited: requested dates will be accommodated where possible.</i>			

## SCREENING & PRECAUTIONS

<b>RENAL ASSESSMENT</b>  <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) <b>eGFR RESULT</b> (ml/min/1.73 <sup>2</sup> ) <b>DATE COLLECTED</b> (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.	<b>PREFERRED LOCATION(S)</b>
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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