Sinai Health | **Mount Sinai Hospital**
Joseph & Wolf Lebovic Health Complex

CT Requisition Form

600 University Avenue,
Toronto, Ontario, Canada M5G 1X5

C13 (Rev. 11.2011)

MODALITY
CT Request Form
SITE AND LOCATION
5th Floor Medical Imaging - Main Reception Desk
TELEPHONE 416-586-4800 x4418
FAX 416-586-3180

PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL <u>BE RETURNED</u>

| BIRTHDATE | | | HOSPITAL MEDICAL RECORD NO. |
| YYYY | MM | DD | |

SURNAME   GIVEN NAME

ADDRESS (Street, Apt #)

CITY/TOWN   PROVINCE   POSTAL CODE

TELEPHONE

IF RESTRICTED MOBILITY, PLEASE PROVIDE NEEDS

| Health Card Number | Version Code |

EXAMINATION(S):

Clinical History and Indications:

The following MUST be completed by the referring physician: (Please check)

1. Does the patient have a history of **Kidney disease**? Yes ☐ No ☐
   (eg. 1 kidney, renal failure, dialysis)

2. Is the patient diabetic?   Yes ☐ No ☐

3. Previous reaction to IV contrast?   Yes ☐ No ☐

4. Does the patient have a pelvic/ileoanal pouch?   Yes ☐ No ☐

If YES to question #1 or #2, please provide blood work (must be within the last 3 months)

Creatinine _____   eGFR _____

List Diabetic Medications:

Known Allergies:

IF THE PATIENT HAS A KNOWN CONTRAST ALLERGY, THE REQUESTING PHYSICIAN IS RESPONSIBLE FOR ORGANIZING THE PRE-MEDICATION PRIOR TO THE PATIENT'S SCAN. PLEASE FOLLOW THE PRE-MEDICATION INSTRUCTIONS BELOW:

2nd GENERATION ANTIHISTAMINE (CETIRIZINE 10mg) 1 HOUR PRE-EXAMINATION. HISTORY OF PREVIOUS SEVERE REACTION, ANOTHER SCAN WITH CONTRAST IS <u>NOT</u> RECOMMENDED.

REFERRING PHYSICIAN INFORMATION

Name and Initials (Print):   **Doctor's Signature: X**

Telephone: **Fax:**

Requested Appointment Date (if applicable):   **CPSO #**

Mailing Address:

| **MEDICAL IMAGING USE ONLY** | **RADIOLOGIST SIGNATURE:** _____ **RADIOLOGIST NAME (PRINT):** _____ | **PROTOCOL:** |

| **MEDICAL IMAGING USE ONLY** | **APPOINTMENT DATE** (YYYY MM DD) | **APPOINTMENT TIME (24 hr clock)** (HH:MM) |