WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

CT– CARDIAC REQUISITION

Fax requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure.

Patient Information (Please Print)

Name: _____ Date of Birth (MM/DD/YYYY):_____ Sex: ☐ M ☐ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact # ( ) _____ Secondary # ( ) _____ Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ☐ Y ☐ N

WHICH OF THE FOLLOWING MINISTRY OF HEALTH APPROVED INDICATIONS FOR CARDIAC CT IS THE PATIENT PRESENTING WITH? (MUST CHOOSE ONE)

- ☐ Arterial and venous aneurysms
- ☐ Traumatic injuries of arteries and veins
- ☐ Arterial dissection and intramural hematoma;
- ☐ Arterial thromboembolism
- ☐ Vascular congenital anomalies and variants
- ☐ Percutaneous and surgical, vascular interventions
- ☐ Vascular infection, vasculitis, and collagen vascular disease
- ☐ Sequelae of ischemic coronary disease (i.e. myocardial scarring, ventricular aneurysms, thrombi)
- ☐ Cardiac tumours and thrombi
- ☐ Pericardial diseases
- ☐ Cardiac function evaluation, especially in patients in whom cardiac function may not be assessed by magnetic resonance imaging or echocardiography

☐ Other _____

Conventional coronary angiography is technically infeasible, or contraindicated for:

i. A clinically stable symptomatic patient with low to intermediate probability of obstructive coronary disease;
ii. A clinically stable symptomatic patient who has planned surgery for valvular or structural heart disease;
iii. A patient has low to intermediate probability of stent stenosis where the stent has a diameter > 3mm; or
iv. A patient with suspected clinically relevant congenital coronary artery anomalies

IF HISTORY OF CARDIOVASCULAR, CHRONIC KIDNEY DISEASE, DIABETES OR OLDER THAN 60 YEARS, A GFR/CREATININE LEVEL IS NEEDED - (DONE WITHIN 2 MONTHS) _____

Anticoagulant Medication ☐ Y ☐ N BMI: _____ **(If over 40 - Not recommended)**
If yes, indicate: _____
Allergies to IV contrast ☐ Y ☐ N
Patient requires Ativan Rx ☐ Y ☐ N *(If yes, Rx given to patient).*
Diabetic ☐ Y ☐ N
Diabetic Medications: _____
☐ ECG Report (send copy) ☐ ***Send all relevant reports - stress test, etc.***

CARDIAC HISTORY AND SURGERY: _____

CARDIAC MEDICATIONS: _____

☐ **RX: 50 mcg PO Metoprolol** ***(Rx given to patient) If not prescribed state reason:*** _____

FOR CAT SCAN USE ONLY

RADIOLOGIST: RA BA AB LB PC MC FD KF IG DG JH MK WR RS JS MT WT MR VS _____

PRIORITY LEVEL		DESCRIPTIONS	CT CARDIAC INSTRUCTIONS (RADIOLOGIST)
1	☐	Emergency	_____
2	☐	In-Patient	_____
3	☐	Urgent	_____
4	☐	Semi-Urgent	_____

Print Referring Physician: _____ Fax Number:_____

Referring Physician Signature:_____

Physicians who require copy of report: _____

APPOINTMENT:

DATE (MM/DD/YYYY):_____ TIME: _____ CAMPUS: _____