WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

CT REQUISITION

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

INCOMPLETE / ILLEGIBLE REQUESTS WILL BE RETURNED - Resulting in delay of appointment booking

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

TYPE OF SCAN - AREAS OF CONCERN

- ☐ HEAD - Area of concern: _____
- ☐ HEAD / ORBIT
- ☐ SINUS/FACE
- ☐ NECK
- ☐ CHEST
- ☐ CHEST ABDOMEN PELVIS
- ☐ ABDOMEN**
- ☐ PELVIS**
- ☐ ABDOMEN / PELVIS** _____
- ☐ BONY PELVIS - No prep
- ☐ CT ENTEROCLYSIS
- ☐ CT RENAL COLIC: _____
- ☐ CERVICAL SPINE - Indicate Levels:_____
- ☐ THORACIC SPINE - Indicate Levels: _____
- ☐ LUMBAR SPINE - Indicate Levels: _____
- ☐ CT ANGIO - Area of Concern:_____
- ☐ LOW DOSE CHEST
- ☐ CT BIOPSY - Area: _____
- ☐ EXTREMITIES: _____
- ☐ Virtual Colonoscopy - ***Patient will be required to pick-up preparation package at WRO pharmacy***
- ☐ Other:_____

CLINICAL INFORMATION / DIFFERENTIAL DIAGNOSIS - PLEASE PRINT

Does patient have allergy to dye? ☐ Yes ☐ No
Does patient require assistance on/off table (wheelchair)? ☐ Yes ☐ No

RELEVANT PREVIOUS DIAGNOSTIC EXAMS - MR / CT / US / NUCMED / XRAY - ATTACH REPORTS

Is the Patient over the age of 70?	☐ Yes	☐ No	Sepsis	☐ Yes	☐ No
Dehydration or volume contraction	☐ Yes	☐ No	HIV / AIDS	☐ Yes	☐ No
Previous Chemotherapy	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No
Vascular Disease / Nephrotoxic Drugs	☐ Yes	☐ No	Acute Hypotension	☐ Yes	☐ No
Collagen Vascular Disease	☐ Yes	☐ No	Diabetes Mellitus	☐ Yes	☐ No
Renal Disease or Solitary kidney	☐ Yes	☐ No	First Nation Person	☐ Yes	☐ No
Hypertension / High Blood Pressure	☐ Yes	☐ No			

IF YES, to any of these questions attach lab results with creatinine level.
Canadian Association of Radiologists Consensus guidelines for the prevention of contrast induced nephrophy (Approved June 17, 2011)

RADIOLOGIST USE

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

CT PROTOCOL	PRIORITY LEVEL	TIME FRAME
☐ WITH CONTRAST	☐ 1	Within 24 hours
☐ WITHOUT CONTRAST	☐ 2	Within 48 hours
☐ W-WO CONTRAST	☐ 3	Within 10 days
☐ ORAL	☐ 4	Within 27 days

Exam Name: _____

Print Referring Physician: _____ Fax Number:_____

Referring Physician Signature:_____

Physicians who require copy of report: _____

APPOINTMENT:

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