

CT REQUISITION – this form can be found on www.swpca.ca Check one Site:

- | | | | |
|---|-----------------|--|-----------------|
| <input type="checkbox"/> Alexandra Marine and General Hospital-Goderich | F: 519-524-8532 | <input type="checkbox"/> Middlesex Hospital Alliance - Strathroy | F: 519-246-5930 |
| <input type="checkbox"/> Grey Bruce Health Services - Owen Sound | F: 519-376-3952 | <input type="checkbox"/> South Bruce Grey Health Centre -Walkerton | F: 519-881-1388 |
| <input type="checkbox"/> Hanover and District Hospital | F: 519-364-0062 | <input type="checkbox"/> St. Joseph's Health Care London | F: 519-646-6204 |
| <input type="checkbox"/> Huron Perth Health Care Alliance - Stratford | F: 519-272-8247 | <input type="checkbox"/> St. Thomas Elgin General Hospital | F: 519-631-8842 |
| <input type="checkbox"/> Listowel Memorial Hospital | F: 519-291-2813 | <input type="checkbox"/> Tillsonburg District Memorial Hospital | F: 519-842-4299 |
| <input type="checkbox"/> LHSC - UH | F: 519-663-3034 | <input type="checkbox"/> Woodstock Hospital | F: 519-421-4238 |
| <input type="checkbox"/> LHSC - VH /Children's | F: 519-667-6826 | | |

PATIENT INFORMATION:

Surname: _____ First Name: _____ Middle Initial: _____
 Gender: M F X Date of Birth (YYYY-MM-DD): _____
 Street Address: _____ Apt: _____ City: _____ Province: _____ Postal Code: _____
 Health Card No. : _____ Version Code: _____ Research or 3rd Party No.: _____
 Telephone (Day): _____ (Evening): _____ (Cell): _____
 Outpatient Long Term Care Inpatient ED
 WSIB: Y N _____ WSIB No.: _____ Date of Injury (YYYY-MM-DD): _____
 Mobility: Ambulatory Wheelchair Stretcher Mechanical Lift Preferred Language: EN OTHER _____
 Considerations: Claustrophobia Mild Sedation (not provided) General Anaesthesia Paediatric Interpreter Required

Y N Please check the following:

- Allergic to radiographic contrast
- Pregnant _____ wks.
- Heparin Flush Ordered
- Power PICC
- CT Porta Cath
- History of Cancer

Precautions

- TB MRSA
- VRE Shingles

**If yes to any of the risk factors please draw creatinine levels

Y N Contrast Risk Factors:

- Diabetic
- On dialysis
- History of impaired renal function or Nephrectomy
- Patient > 70 yrs old
- On any diabetic medications: _____
- Hypertension
- Medications/conditions predisposing to nephrotoxicity
- Other: _____

- Y N Related surgery

- Y N Urgent
- Y N Routine
- Y N Timed _____
- Y N Cancer
- Y N Staging/ Followup
_____ Timing of above

Please attach previous imaging and reports (ie ECG)

REFERRING PHYSICIAN:

Name _____ Address: _____
 City: _____ Postal Code: _____ Tel: _____ FAX: _____
 Physician's Signature: _____ Billing No: _____
 Copy to: _____ Date: _____

Serum Creatinine (must be drawn within the past 6 months)

Result: _____
 eGFR: _____
 Sample date: _____
 Height: cm/in. _____
 Weight: kg/lbs. _____

EXAMINATION REQUESTED:

WORKING DIAGNOSIS:

CLINICAL INFORMATION:

FOR BOOKING STAFF

Prep Information

- No prep required
- Clear fluids only 4 hours prior
- Drink 1 bottle of water en route & do not void
- Patient may be here 2+ hours
- Bring list of medications
- Start IV # _____
- Consent obtained by MRP

Appointment Date:

Arrival Time:

OFFICE USE ONLY

Protocol:

- Water Prep Barium Water Soluble Enterography Prep
- IV Rectal Non Contrast without and check
- Nitro Beta Blockers Hyoscine (Buscopan)
- P1 P2 P3 P4 Timed: _____
- Staff Initials: _____

FOR TECHS/RADS

NOTE: This requisition may be booked at an alternate site in the South West LHIN to improve patient access.