ST JOSEPH'S HEALTH CENTRE TORONTO

OUTPATIENT CT REQUISITION (CONTRAST AND NON-CONTRAST)

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

Name:_____
Male ☐ Female ☐
MRN :_____
DOB:_____
Address:_____
_____
Telephone:_____
OHIP #:_____

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

TYPE OF CT SCAN:_____

STUDY PRIORITY: ☐ STAT/TODAY (Call to CT Radiologist) ☐ URGENT ☐ ROUTINE WSIB/Third Party Claim Number:_____

CURRENT PATIENT LOCATION: ☐ EMERGENCY ☐ Inpatient ☐ Clinic/ACC ☐ Outpatient

CLINICAL HISTORY Isolation Precautions: ☐ N/A ☐ Contact ☐ Droplet ☐ Airborne ☐ Reverse

(For Oncology Patients: Specify Date for Follow-Up : _____)

MANDATORY INFORMATION

ALLERGY TO IV CONTRAST? ☐ YES ☐ NO
Patient Pre-medicated: ☐ YES ☐ NO

•If the patient has a known contrast allergy, the requesting physician is responsible for organizing the Premedication prior to patient's CT exam. See Pre-medication (see below).

Pre-medication Instructions for Allergic Patients:

•Prednisone 50mg P.O. 13hrs, 7hrs and 1hr pre-CT exam.

•Benadryl 50mg P.O. 1hr pre-CT exam.

Benadryl can cause drowsiness. These patients should make arrangements to be driven to and from the examination.

CONTRAINDICATION TO IV CONTRAST? ☐ YES ☐ NO
(If yes, describe_____)

• Is the patient on HEMODIALYSIS? ☐ YES ☐ NO
(If yes, Days: _____ Time:_____)

• Does the Patient Consent to Appointment Information Being disclosed in a phone message? ☐ YES ☐ NO

• Is the patient able to come in a short notice? ☐ YES ☐ NO

• Contact Telephone Number_____

• Falls Risk ? ☐ YES ☐ NO

FOR PATIENTS WITH ANY OF THE FOLLOWING RISK FACTORS:

A recent eGFR level MUST be provided for all enhanced CT studies :

- Greater than 60 years of age ☐ YES ☐ NO
- Diabetes mellitus ☐ YES ☐ NO
- Hx of renal disease ☐ YES ☐ NO
- Solitary kidney ☐ YES ☐ NO
- Hx of severe liver disease ☐ YES ☐ NO
- Previous organ transplant ☐ YES ☐ NO

eGFR (mL/min) : _____ (date of bloodwork)_____

For patients with any above risk factors: If the CT exam is scheduled for a date after 3 months of the provided eGFR result, an updated eGFR must be faxed to (416) 530-6060 no later than 7 days prior to the appointment date to avoid cancellations/delays.

For patients on Metformin: The patient should be informed to hold Metformin for 48hrs following the injection of IV Contrast. Blood test is required after 48hrs to determine whether Metformin can be resumed. The requesting physician or the family physician will need to arrange this for their patient.

REQUESTING PHYSICIAN

Physician Name:_____ Telephone Number:_____

Physician Speciality:_____ Pager Number:_____

Address:_____ Fax:_____

City:_____ Postal Code:_____ Copies to:_____

DATE/TIME	SIGNATURE	PRINT NAME (Physician's Printed Name)