

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

Patient Information (Please Print)

Name: _____ Date of Birth (D/M/Y): _____ 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

ALL EXAMS—NOTHING SOLID BY MOUTH 3 HOURS PRIOR TO EXAM. (Except for Spines/Extremities/Renal Colic - NO RESTRICTIONS)

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

CLINICAL INFORMATION / DIFFERENTIAL DIAGNOSIS - PLEASE PRINT

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

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

CT PROTOCOL

- WITH CONTRAST
 WITHOUT CONTRAST
 W-WO CONTRAST
 ORAL

PRIORITY LEVEL

- 1
 2
 3
 4

TIME FRAME

- Within 24 hours
 Within 48 hours
 Within 10 days
 Within 28 days

Exam Name: _____

Print Referring Physician: _____ Fax Number: _____

Referring Physician Signature: _____

Physicians who require copy of report: _____

APPOINTMENT:

DATE: _____ **TIME:** _____ **CAMPUS:** _____