

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

**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

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

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

PRIORITY LEVEL	DESCRIPTIONS	CT CARDIAC INSTRUCTIONS (RADIOLOGIST)
1 <input type="checkbox"/>	Emergency	_____
2 <input type="checkbox"/>	In-Patient	_____
3 <input type="checkbox"/>	Urgent	_____
4 <input type="checkbox"/>	Semi-Urgent	_____

Print Referring Physician: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_

Physicians who require copy of report: \_\_\_\_\_

**APPOINTMENT:**

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_ **CAMPUS:** \_\_\_\_\_