William Osler Health System

Diagnostic Imaging CT

Fax: 905-494-6618 Next available appointment **OR** Brampton Civic Hospital Etobicoke General Hospital Peel Memorial Centre

Patient Information

Name:______________________________ Date of Birth*(DD/MM/YYYY)*:______________
Health Card No:______________________________ Version Code:______________
Address:______________________ City:____________ Prov.:______ Postal Code:____________
Tel:______________________ Email:______________________________

To **request DI exam for discharged ED / UCC patient**, select time frame* for DI exam, and send patient with this requisition to the DI remote / EDDI desk to book DI exam. **Do not fax this requisition.** ☐ Less than 24h ☐ Less than 48h ☐ Less than 10 days ☐ Less than 1 month

Examination Requested

Head:
- Routine
- Paranasal Sinuses

Neck:
- Routine

Chest:
- Routine
- Low Dose
- High Resolution
- Coronary Calcium Scoring

For Cardiac CTA please use Cardiac CT requisition

Abdomen:
- Routine
- Renal Colic
- Liver
- Pancreas
- Kidneys
- Adrenals
- Urogram
- Enterography
- Colonography

Pelvis:
- Routine

Vascular:
- Pulmonary Embolus
- Femoral Runoff
- Abdominal Aortic Aneurysm
- Carotid
- Circle of Willis
- Thoracic Angiogram

Musculoskeletal:
- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Bony Pelvis/Hips
- Extremity (specify): __________
- Skeletal Survey

Other (specify): ______________________

Clinical Questionnaire

Clinical History (Mandatory):

____

Has relevant imaging of the area been performed? Yes No If yes, specify site: ______________________

1. Age 70 or up? Y N
2. Is patient diabetic? Y N
If yes, is patient taking any medication containing Metformin* Y N
***Metformin containing drugs should be held following IV contrast administration and serum creatinine repeated 48 hours after CT and verified before restarting. Patient will be given an information sheet after CT scan regarding this.**
3.a. History of renal risk factors, such as single Kidney Renal CA/Transplant/Surgery? Y N
If yes to question 1, 2 or 3a, order Serum creatinine and fax results with requisition

3.b. History of myasthenia gravis? Y N
4. Is patient on dialysis? Y N
If yes: Days and Time____________
Urine output? Y N
5. Has patient had previous contrast injection? Y N
6. Allergy to contrast? Y N
If yes, the requesting provider must prescribe the following medication:
predniSONE 50mg P.O. 13 hours, 7 hours, and 1 hour pre-CT AND diphenhydrAMINE 50 mg P.O. 1 hour pre-CT

7. Blood Work:
Last blood work date:____________
Creatinine: ____________________
eGFR: (Within last 3 months) ________
Patient weight: __________(kg)

DI USE ONLY
If eGFR less than 30 and contrast indicated, then give 0.9% NaCl 300mL IV over 1 hour pre CT and 0.9 % NaCl infuse at 350 mL/hr x 2 hour post CT

Provider Name (Print): ____________________________CPSO/OHIP Billing #: __________

Telephone: ____________________________ Fax: ____________________________

Copies to (Provider Name): ______________________________________

Provider Signature: ______________________________Date :______________

PROTOCOL
P1 P2 P3 P4
Protocol: Mnemonic:

***Booking date is dependent on appointment availability and radiologist supervised clinical triaging based on provided clinical history**
NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING
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