

# Request for CT Consultation

(Computed Tomography)

HNHB LHIN

Last Name		First Name	
HIN/HCN/OHCN/OHIP #		Date of Birth (yyyy/mm/dd)	
Address			
City / Province		Postal Code	
Phone Number:		Mobile Number:	
Gender	Weight (kg)	Age	

REQUEST TO: Referral Date: \_\_\_\_\_

- ☐ **Brantford General Hospital**  
Phone: 519-751-5545  
Fax: 519-752-9983
- ☐ **Greater Niagara General**  
Phone: 905-378-4647  
Fax: 905-358-7438
- ☐ **Haldimand War Memorial Hospital (Dunnville)**  
Phone: 905-774-7431  
Ext: 1221  
Fax: 905-774-7914
- ☐ **Hamilton General Hospital**  
Phone: 905-521-2100  
Ext: 49600  
Fax: 905-527-9053
- ☐ **Joseph Brant Hospital**  
Phone: 905-336-4126  
Fax: 905-336-4148
- ☐ **Juravinski Hospital & Cancer Centre (Hamilton)**  
Phone: 905-389-4411  
Ext: 41484  
Fax: 905-387-8813
- ☐ **McMaster University Medical Centre & Children's Hospital (Hamilton)**  
Phone: 905-521-2100  
Ext: 41484  
Fax: 905-521-5086
- ☐ **Norfolk General Hospital**  
Phone: 519-426-0130  
Ext: 2219  
Fax: 519-429-6892
- ☐ **St. Catharines Hospital**  
Phone: 905-378-4647  
Fax: 905-684-6990
- ☐ **St. Joseph's Healthcare (Hamilton)**  
Phone: 905-522-1155  
Ext: 35278  
Fax: 905-521-6166
- ☐ **Welland Hospital**  
Phone: 905-378-4647  
Fax: 905-732-9537

**Referring Physician:** \_\_\_\_\_ **Unit:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Printed Name Signature & Designation

**Hospital/Other Facility:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Send Additional Report to:** ☐ Primary Care Physician ☐ Other: \_\_\_\_\_  
Printed Name Phone Number Fax

**Exam Payee:**  
☐ OHIP ☐ WSIB # ☐ Self ☐ Third Party  
Specify: \_\_\_\_\_

**Patient Routing:**  
☐ Hospital preference: \_\_\_\_\_  
☐ Next available appointment at any hospital

**Exam Requested** (be specific):

**Current Patient Location:**  
☐ Inpatient ☐ Outpatient ☐ Emergency

**Language Preferred:** ☐ English ☐ French ☐ Other: \_\_\_\_\_

**Interpreter Required?** ☐ Yes ☐ No

**Clinical Information / Relevant History:**

**Please answer all of the following questions:**

1) Known Renal Disease? **YES / NO**

2) Known Diabetes? **YES / NO**

3) On Metformin? **YES / NO**

If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:

eGFR: \_\_\_\_\_ ml/min/1.73<sup>2</sup> Date (yyyy/mm/dd): \_\_\_\_\_

Creatinine: \_\_\_\_\_ ml/min/1.73 Date (yyyy/mm/dd): \_\_\_\_\_

4) **Known Contrast Allergy?**  
If **yes**, has the patient been provided with the pre-medication instructions listed below:

☐ Prednisone **50 mg** PO 12 hours and 2 hours pre-procedure

☐ Diphenhydramine **50 mg** PO/IV 1 hour pre-procedure

**Relevant tests to date:**

**If this is a follow-up exam, please indicate requested date:**

\_\_\_\_\_ (yyyy/mm/dd)

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Printed Name Signature & Designation (yyyy/mm/dd)

**Priority:** 1 2 T2 3 T3 4 T4 **Test Date:** \_\_\_\_\_ **Test Time:** \_\_\_\_\_  
(yyyy/mm/dd) (hh:mm)

**Clinical Indication:** ☐ Cancer ☐ Other: \_\_\_\_\_

**Protocol:** \_\_\_\_\_ **Radiologist (printed):** \_\_\_\_\_  
Date Protocolled: (yyyy/mm/dd)

**Additional Comments:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

FOR CT USE ONLY