UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute
TGH 585 University Av. Toronto, Ont.
TWH 399 Bathurst St. Toronto, Ont.
PMH 610 University Av. Toronto, Ont.
TR 550 University Av. Toronto, Ont.
T • 416-340-3384
F • 416-340-4661

Sinai Health
600 University Av. Toronto, Ont.
T • 416-586-4418
F • 416-586-3180

WCH WOMEN'S COLLEGE HOSPITAL Health care for women | REVOLUTIONIZED
T • 416-323-7515
F • 416-323-6316

Medical Imaging CT Requisition Form

Requisition Completed on: _____
yyyy / mm / dd

PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL BE RETURNED

SURNAME	GIVEN NAME
BIRTHDATE: YYYY MM DD	HOSPITAL MEDICAL RECORD NO.
ADDRESS: (Street, Apt. #:)	
CITY/TOWN PROVINCE POSTAL CODE	
MOBILE PHONE NUMBER (preferred) (Area Code & Number) ( ) _____ - _____	
Health Card Number Version Code	
EXAMINATION(S)	
Clinical History and Indications:	

❒ **Routine** ❒ **Emergent** ❒ **Acute** ❒

The following MUST be completed by the referring physician: (Please check)

1. Does the patient have a history of **Kidney disease? (eg. 1 kidney, renal failure, dialysis)** Yes ❒ No ❒
2. Is the patient diabetic? Yes ❒ No ❒
3. Previous reaction to IV contrast? Yes ❒ No ❒
4. Does the patient have a pelvic/ileoanal pouch? Yes ❒ No ❒

If YES to question #1 or #2, please provide blood work (must be within the last 3 months)

Creatinine_____ eGFR_____

List Diabetic Medications:

Known Allergies:

IF THE PATIENT HAS A KNOWN CONTRAST ALLERGY, THE REQUESTING PHYSICIAN IS RESPONSIBLE FOR ORGANIZING THE PRE-MEDICATION PRIOR TO THE PATIENTS SCAN, PLEASE FOLLOW THE PRE-MEDICATION INSTRUCTIONS BELOW:

PREDNISONE 50mg P.O 13 HOURS AND 1 HOUR PRE-EXAMINATION PLUS BENADRYL 50mg P.O 1 HOUR PRE-EXAMINATION.
NOTE: BENADRYL CAN CAUSE DROWSINESS, PATIENTS SHOULD MAKE ARRANGEMENTS TO BE DRIVEN TO AND FROM THE EXAMINATION.

Patient Weight: _____kg/lbs.

Date of last LMP:_____
yyyy / mm / dd

C13

Previous applicable surgery:_____ Relevant post-surgery & medical therapy _____

REFERRING PHYSICIAN INFORMATION	
Name and Initials (Print):	**Doctor's Signature:**
Telephone #: ( )	**Fax #: ( )**
Requested Appointment Date (if applicable):	**Billing & CPSO #** REQUIRED

Mailing Address: _____

CC report to: _____

Interpreter required if **YES** what language: _____