NORTHUMBERLAND HILLS HOSPITAL

N401

CT Requisition

Phone (905) 377-7752 Fax (905) 373-6922

Place Patient Identification Label Here

Please fax all CT Requisitions to NHH CT Bookings at (905) 373-6922

In Patient ☐ Out Patient ☐

Is the patient capable to sign consent? Yes ☐ No ☐

If No, please ask the appropriate signing delegate to accompany the patient the day of the examination.

Suggested Clinical Priority: 2 3 4 ST = Specified Date

Specific Date: _____

All EMERGENT requests must be made by the referring physician speaking directly to the CT Radiologist or "on-call" radiologist.

Area to be scanned:

History:

INCOMPLETE, UNSIGNED OR ILLEGIBLE REQUISITIONS WILL BE RETURNED

Clinical Indicator: **BC** Breast Cancer **OT** Other
(Please circle) **SD** Cancer Staging and/or Diagnosis

FOR CT GUIDED BIOPSIES: ***Please fax a copy of the patient's recent history and physical along with the CT request.***

Has a Radiologist been notified? ***YES*** ☐ _____
Name of Radiologist

Date Physician's Signature

____/____/____ _____

NHH Diagnostic Imaging Use Only

Radiologist Protocol: Priority 1 2 3 4 _____

Radiologist's Initials: _____ **Date/Time:** _____

Last Name: _____

First Name: _____

Address: _____

City: _____ P. Code _____

Phone: (____) _____-_____ D.O.B: _____

Health Card #:

☐☐☐☐ ☐☐☐ ☐☐☐ ☐☐

WSIB Claim #: _____ (HC version code)

☐ CT will contact patient directly with an appointment unless this box is checked

☐ Speak to Patient only ☐ Patient's consent to leave message

☐ Contact POA or other _____

Contact's Name: _____ Tele#: _____

Ordering Physician Data

Name:

OHIP Billing#: CPSO#:

Phone: Fax:

Copies To:
(Include Address)

REQUIRED INFORMATION FOR ALL CT PATIENTS
(except requests for Spines, Sinuses or Shoulders)

Serum Creatinine (date) _____(_____)
(Results must be from within last 2 months)

Weight: _____ lbs _____ kg **(Required)**

	YES	***NO***
Kidney Disease	☐	☐
Multiple Myeloma	☐	☐
Metformin®	☐	☐

Patient should not take Metformin the day of the CT examination

History of Endocarditis	☐	☐
Heart Valve Replacement	☐	☐

	YES	***NO***
Previous IV Contrast Injection?	☐	☐
Adverse Reaction?	☐	☐

If Yes, describe:

Appointment Date: _____

Patient Notified: _____

Northumberland Hills Hospital is fragrance free. Perfume, after shaves or colognes, strongly scented soaps or deodorants are not permitted due to potential allergic reactions by both patients and staff. Form: 401 (10/19)