ST. JOSEPH'S
UNITY HEALTH TORONTO

S1045

CT OUTPATIENT REQUISITION
(CONTRAST AND NON-CONTRAST)

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

Name: _____
Male ☐ Female ☐
MRN :
DOB: _____
Address: _____

Telephone: _____
OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

TYPE OF CT SCAN: _____

STUDY PRIORITY: ☐ **STAT (within 4 hours, requires call to CT Radiologist)** ☐ **TODAY** ☐ **URGENT (1-2 days)** ☐ **ROUTINE**

CURRENT PATIENT LOCATION: ☐ **Outpatient** ☐ **Clinic/ACC** **WSIB/Third Party Claim Number:** _____

CLINICAL HISTORY **Isolation Precautions:** ☐ **N/A** ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Reverse**

(For Oncology Patients: Specify Date for Follow-Up: _____**)**

MANDATORY INFORMATION

ALLERGY TO IV CONTRAST? ☐ YES ☐ NO
Patient Pre-medicated: ☐ YES ☐ NO

• If the patient has a known contrast allergy, the requesting physician is responisible for organizing the Premedication prior to patient's CT exam. See Pre-medication (below)

Pre-medication Instructions for Allergic Patients:
• Prednisone 50mg P.O. 13hrs, 7hrs and 1hr pre-CT exam.
• Benadryl 50 mg P.O. 1hr pre-CT exam.

Benadryl can cause drowsiness. These patients should make arrangements to be driven to and from the exam.

CONTRAINDICATION TO IV CONTRAST? ☐ YES ☐ NO
(If yes, describe _____**)**
• Is the patient on **HEMODIALYSIS?** ☐ YES ☐ NO

• Does the Patient Consent to Appointment Information Being disclosed in a phone message? ☐ YES ☐ NO
• Is the patient able to come in a short notice ☐ YES ☐ NO
• Contact Telephone Number _____
• Falls Risk? ☐ YES ☐ NO

FOR PATIENTS WITH ANY OF THE FOLLOWING RISK FACTORS:

A recent eGFR level MUST be provided for all enhanced CT studies:

• Greater than 60 years of age ☐ YES ☐ NO
• Diabetes mellitus ☐ YES ☐ NO
• Hx of renal disease ☐ YES ☐ NO
• Solitary kidney ☐ YES ☐ NO
• Hx of severe liver disease ☐ YES ☐ NO
• Previous organ transplant ☐ YES ☐ NO

eGFR (mL/min): _____ (date of bloodwork) _____

For patients with any above risk factors: If the CT exam is scheduled for a date after 30 days of the provided eGFR result, an updated eGFR must be faxed to (416) 530-6060 no later than 7 days prior to the appointment date to avoid cancellations/delays.

REQUESTING PHYSICIAN

Physician Name: _____ Telephone Number: _____

Physician Speciality: _____ Pager Number: _____

Address: _____ Fax: _____

City: _____ Postal Code: _____ Copies to: _____

DATE/TIME	SIGNATURE	PRINT NAME (Physician's Printed Name)