ST. MICHAEL'S
UNITY HEALTH TORONTO

Medical Imaging
30 Bond Street, Toronto, ON, M5B 1W8
3rd Floor, Cardinal Carter Wing
Website- http://bit.ly/2ucQCPA

CT Requisition

Fax 416-864-3019
Tel. 416-864-5656

FOR MI OFFICE USE ONLY
Exam Date: _____
Arrival Time: _____
Exam Time: _____

A. PATIENT INFORMATION

MRN **DOB** *YYYY/MM/DD*

Health Card #: _____ **Version Code:** _____

Last Name

First Name

Street Address

City **Postal Code**

Province **Country**

☐ **Interpreter: Language** _____

☐ **Restricted Mobility, Please describe needs**

_____

☐ **Isolation** _____

☐ **Self Pay** ☐ **IFH** ☐ **WSIB Claim #:** _____

☐ **Female**

☐ **Male** ☐ **Intersex**

☐ **Transgender - Female to Male**

☐ **Transgender - Male to Female** ☐ **Please Specify** _____

Patient Consents to leave message ☐ **Yes** ☐ **No**

MOBILE: _____

HOME: _____

WORK: _____

B. EXAM INFORMATION

EXAM REQUESTED:

DATE OF REQUEST: *YYYY/MM/DD*

CLINICAL INFORMATION: (be specific)

C. MEDICAL HISTORY **MANDATORY FOR ALL CONTRAST CT EXAMS - INCOMPLETE REQUESTS WILL BE RETURNED**

Is the patient pregnant? ☐ **YES** ☐ **NO**

Patient Height: _____ **Patient Weight:**_____

If the answer is YES to any of the questions below, a serum Creatinine/eGFR MUST be provided in order to avoid cancellation.

Creatinine result must be from within 6 months prior to scan date.

Does the patient have HHT or history of Pulmonary AVMs?

☐ **YES** ☐ **NO**

1. Does the patient have kidney problems?	☐ **YES**	☐ **NO**	**BLOODWORK**	**(RESULTS MUST BE WITHIN 6 MOS)**
2. Does the patient have a kidney transplant?	☐ **YES**	☐ **NO**	**Creatinine:**	**eGFR:**
3. Has the patient seen or been referred to urologist or nephrologist?	☐ **YES**	☐ **NO**	**Date:**	

D. CONTRAST ALLERGY

Is the patient allergic to iodinated IV contrast media?

☐ YES ☐ NO

***If yes, please follow the pre-medication protocol here →

Pre-medication Instructions for IV Contrast Allergy

1. Prednisone 50mg PO - 13hrs, 6 hrs and 1hr before scan
2. Benadryl 50mg PO - 1hr before scan

E. ORDERING PHYSICIAN INFORMATION & SIGNATURE

Ordering Physician Name (please print):	Copy to
Signature: Date:	
CPSO # :	BILLING #
FAX # :	PHONE #