SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Imaging - FAX: 905-830-5966

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Phone #: _____

CT Requisition

❑ OUT-PATIENT ❑ IN-PATIENT ❑ ED PATIENT ❑ ED CALLBACK

Patient Name: *(print first, last)*
Address: Street Number + Name Apartment
City Province Postal Code
Health Card Number: **Version Code:**
Other Insurance: **WSIB Number:**
Home: ( ) **Work/Other:** ( )
Patient not available: From: dd / mm / yy To: dd / mm / yy
Reason:
Area to be scanned:
Clinical Question:

RELEVANT CLINICAL INFORMATION: *(must be provided and please be specific)*

Appointment Date: dd / mm / yy
Appointment Time:
Arrival Time:
Hospital Record #:
Date of Birth: _____/_____/_____
Patient Weight: _____ **kg**

RENAL FUNCTION ASSESSMENT
(please check (✓) appropriate)
❑ Hx of Renal Disease:
Creatinine= _____ obtained on dd / mm / yy
eGFR= _____
❑ On Dialysis: Does the patient make greater than 100ml of urine per day? ❑ Yes ❑ No
❑ Acute Kidney Injury (AKI): for IN-patient/ ED patients only
❑ The patient has **NONE** of the above risk factors.

Venous Access in situ: ❑ Port ❑ PICC
Allergy to contrast ❑

Referring Physician: *(print first, last)* **CPSO #** **Date:** dd / mm / yy
Signature: **Office Phone:** ( )
Address: **Fax Number:** ( )

RADIOLOGIST USE ONLY

Head	❑ Without Contrast	❑ With Contrast
Neck	❑ Without Contrast	❑ With Contrast
Thorax	❑ Without Contrast	❑ With Contrast
Abdomen	❑ Without Contrast	❑ With Contrast
Pelvis	❑ Without Contrast	❑ With Contrast
Triphasic Liver	❑ Without Pelvis	❑ With Pelvis
Renal Mass	❑ Without Pelvis	❑ With Pelvis
Pancreas	❑ Without Pelvis	❑ With Pelvis
Facial Bones	❑ Without Mandible	❑ With Mandible
Spine	❑ C-spine	❑ L3 to S1
	❑ Other _____	
High Res Chest	❑ Inspiration ❑ Bronchiectasis ❑ Interstitial	
Thorax	❑ Aneurysm	❑ Dissection
Abdomen	❑ Aneurysm	❑ Dissection
Pelvis	❑ Aneurysm	❑ Dissection

❑ **Sinuses**	❑ **Wrist**	❑ **Pulmonary Angio**
❑ **Renal Colic**	❑ **Hip**	❑ **Carotid Angio**
❑ **Urogram**	❑ **Ankle/Foot**	❑ **Circle of Willis**

Protocol Notes:
❑ With Oral Contrast

Priority: *(please circle)*
1 2 3 4

Is this a specified date (timed) procedure?
If yes, specify date: _____

Clinical Indications for Scan:
❑ Cancer Staging and/or Diagnosis
❑ Other Diagnosis

Radiologist/MRT (R): *(print first, last)*

Radiologist/MRT (R) Signature:

The collecting of personal information on this form is done in accordance with Southlake's Privacy Policy. Details are available on our website, www.southlakeregional.org

SL0260_25 (5/20) "Diagnostic Imaging" Review (6/23)

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Diagnostic Imaging

Patient Preparation and Information

Patient Preparation for CT Abdomen and/or Pelvis:
• Drink 1 litre of water 1 hour prior to scan time. • Take medication(s) as usual.

PATIENT INFORMATION:

- **Bring your Ontario Health Card.**
- Upon arrival you are required to register for your appointment at one of our Welcome Centres before proceeding to Diagnostic Imaging Reception on East 2.
- If you are unable to keep your appointment, please call Patient Scheduling at 905-895-4521, ext. 2665.

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