NORTH YORK GENERAL
Making a World of Difference

Medical Imaging Department
4001 Leslie Street
Toronto, ON M2K 1E1
T 416-756-6190
F 416-756-6192

COMPUTED TOMOGRAPHY (CT) REQUISITION

Form PS194 Rev. 11/2017

Name: _____
Male ☐ Female ☐
MRN: _____
DOB: _____
Address: _____
Telephone: _____
Health Card Number #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

EXAMINATION(S) REQUESTED:

CLINICAL HISTORY:

PRIOR SURGICAL HISTORY:

FOR OFFICE USE ONLY

Protocol Priority: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Special Codes: ☐ CS ☐ OT ☐ Timed

Date_____

Signature_____

Appointment_____

RENAL FUNCTION SCREENING FOR PATIENTS REQUIRING INTRAVASCULAR IODINATED CONTRAST MEDIA

Complete the following section for patients requiring intravascular iodinated contrast media (select all applicable risk factors). Creatinine/eGFR is required for patients with one or more risk factors. If there are no risk factors, select NONE of the above:

- ☐ Age > 70 years
- ☐ History of renal disease (kidney transplant, single kidney, renal surgery, dialysis/chronic renal failure)
- ☐ Hypertension requiring two or more medications
- ☐ Risk for acute kidney injury (e.g. hypotension dehydration, sepsis)
- ☐ In a sickle cell crisis
- ☐ Type 1 or Type 2 diabetes
- ☐ Taking metFORMIN or metFORMIN-containing agent
- ☐ Taking a nephrotoxic medication, e.g. acyclovir, amphotericin, aminoglycosides, vancomycin, lithium
- ☐ Receiving chemotherapy
- ☐ **NONE of the above**

Creatinine Result: μmol/L	Result acceptable within 90 days if eGFR is ≥ 60 mL/min/1.73 m^2 Result acceptable within 30 days if eGFR is < 60 mL/min/1.73 m^2
eGFR Result/Calculation: mL/min/1.73m^2	
Date of Result (include copy):	

ALLERGY, PRIOR EXAMS AND APPOINTMENT INFORMATION

Allergy to IV Iodinated Contrast? ☐ YES ☐ NO

If YES, describe reaction:_____

Reports from relevant prior exams must be included with requisition

If patient is not English speaking, please ask patient to have an interpreter accompany them for their exam

REQUESTING PROVIDER

Address:_____

City:_____ Postal Code:_____

Telephone Number:_____

Fax Number:_____

Billing Number:_____

Copy to:_____

DATE/TIME	SIGNATURE (REQUESTING PROVIDER)	PRINT NAME
DD / Month / YYYY ____:__ __h		

By the use and submission of this requisition, it is acknowledged that NYGH can use telephone, text message, or email communication to schedule and coordinate appointments

Approved by MAC NOVEMBER 2017 (Archive: 08/2017)