



COMPUTED TOMOGRAPHY (CT) REQUISITION

Medical Imaging Department 4001 Leslie Street, Toronto ON M2K 1E1 Bookings: 416-756-6190 Fax Line: 416-756-6192

FORM PS194

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Rev. 03/2023

Patient LABEL / Identification Area

1 OKWI 0134 Tage FOIT	1164. 05/20	25	<u> </u>
Patient Name:	Patient	Email Ad	ddress:
INCOMPLETE I	FORMS WILL BE R	ETURNED	AND NOT BE PROCESSED
EXAMINATION(S) REQUESTED			FOR OFFICE USE ONLY
CLINICAL HISTORY:			Protocol
			Signature
PRIOR SURGICAL HISTORY:			Appointment
RENAL FUNCTION SCREENING FOR	PATIENTS REQU	JIRING INT	TRAVASCULAR IODINATED CONTRAST MEDIA
REQUIRED for patients who meet any of the	ne following criteria (check all th	nat apply):
 ☐ History of renal disease (kidney trans dialysis/chronic renal failure etc.) ☐ Has been seen or is waiting to see a function ☐ None of the above 			•
Creatinine Result:	µmol/L		
eGFR Result/Calculation:	mL/min/1.73m ²	Result acceptable within 90 days	
Date of Result (include copy):			
ALLERGY, PRIOR EXAMS AND APPOINTMENT INFORMATION			REQUESTING PROVIDER
Previous Hospitalization for Allergic Reaction? ☐ YES ☐ NO Allergy to IV Iodinated Contrast? ☐ YES ☐ NO		Address:Postal Code:	
If YES, describe reaction:			Telephone Number:
		Fax Number:	
Reports from relevant prior exams must be included with requisition			Billing Number:
If patient is not English speaking, please ask patient to have a translator accompany them for their exam			Copy to:
DATE/TIME	SIGNATURE (RE	QUESTING	PROVIDER) PRINT NAME
DD / Month / YYYY : h			