NORTH YORK GENERAL
Making a World of Difference

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 **Page 1 of 1** **Rev. 03/2023**

Patient LABEL / Identification Area

Patient Name:_____ **Patient Email Address:**_____
By providing your patient's email address you are giving permission to contact the patient via email with appointment time and information

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

EXAMINATION(S) REQUESTED

_____

CLINICAL HISTORY:

PRIOR SURGICAL HISTORY:

FOR OFFICE USE ONLY

Protocol ☐ 1 ☐ 2
Priority ☐ 3 ☐ 4 A / B
Special Codes: ☐ CS ☐ OT
☐ Timed : _____

Signature_____

Appointment_____

RENAL FUNCTION SCREENING FOR PATIENTS REQUIRING INTRAVASCULAR IODINATED CONTRAST MEDIA

REQUIRED for patients who meet any of the following criteria (check all that apply):

- ☐ History of renal disease (kidney transplant, single kidney, renal surgery, dialysis/chronic renal failure etc.)
- ☐ Has been seen or is waiting to see a Specialist due to decreased kidney function
- ☐ None of the above

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

ALLERGY, PRIOR EXAMS AND APPOINTMENT INFORMATION

Previous Hospitalization for Allergic Reaction? ☐ YES ☐ NO
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 a translator 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		