STEVENSON MEMORIAL HOSPITAL

200 Fletcher Crescent
Alliston, Ontario L9R 1W7
Tel: 705-435-6281

TO BOOK AN APPOINTMENT:
Phone: 705-434-5133
Fax: 705-434-5111
Please bring a copy of the requisition with you to your appointment.

Patient Notified _____
Prep Explained _____

APPOINTMENT DATE AND TIME: _____

CT SCAN REQUISITION

Name:	**Health Card #:**
Address:	
Phone #:	**DOB:** (dd/mm/yy)

		Yes	No
1. Is the Patient diabetic?		☐	☐
2. Does the Patient have a solitary kidney?		☐	☐
3. Is there Renal Insufficiency?		☐	☐
4. Is the Patient 60 years old or greater?		☐	☐
5. Has the Patient had a previous reaction to contrast?		☐	☐
eGFR or Creatinine level required if Yes to #1, 2, 3, or 4 Test date: _____/_____/_____ Level (within 3 months):_____		☐	☐
Weight: _____	Is the Patient possibly pregnant?	☐	☐

AREA TO BE SCANNED: *(check box)*

☐ Head ☐ Sinuses ☐ C-Spine ☐ Chest ☐ Neck ☐ Other
☐ Facial Bones ☐ Mastoids/Temporal Bones ☐ T-Spine ☐ Abdomen ☐ Renal Stone Protocol *(please specify)*
☐ Orbits ☐ Sella ☐ L-Spine ☐ Pelvis ☐Extremity ☐R or ☐L _____
☐ CTA, specify: _____

Relevant Clinical Information *(Must be provided):*_____

_____

Clinical Indication for Scan: ☐ Cancer Staging ☐ Cancer Surveillance ☐ Breast Cancer ☐ Other _____

RADIOLOGIST USE ONLY

	Without Contrast	With Contrast	Without/ With Contrast
HEAD	☐	☐	☐
NECK	☐	☐	☐
SPINE	☐	☐	☐
THORAX	☐	☐	☐
ABDOMEN	☐	☐	☐
PELVIS	☐	☐	☐
EXTREMITY	☐	☐	☐
OTHER	☐	☐	☐

_____

☐ Oral Contrast

☐ Rectal Contrast

Priority ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ T Specified Date Procedure:_____

Special Instructions (for Radiologist):

_____
Radiologist Signature

CT SCAN CANNOT BE PERFORMED WITHOUT A REQUISITION SIGNED BY A PHYSICIAN

Referring Physician Printed Name, Phone and FAX and Signature:	**Date:** (dd/mm/yy)