

## OUTPATIENT CT REQUISITION FORM

### PATIENT INFORMATION

<b>SURNAME</b>		<b>FIRST NAME</b>		<b>MIDDLE INITIAL</b>	
<b>ADDRESS</b>			<b>CITY</b>	<b>PROVINCE</b>	<b>POSTAL CODE</b>
<b>MOBILE PHONE #</b>		<b>ALTERNATE PHONE #</b>	<b>EMAIL</b>		
Patient consents to appointment information being disclosed to them via text or e-mail <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, e-mail					
<b>SEX ASSIGNED AT BIRTH</b> <input type="checkbox"/> Female <input type="checkbox"/> Male		<b>GENDER IDENTITY</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		<b>DOB (YYYY/MM/DD)</b>	<b>HEIGHT(CM)</b>
<b>HEALTH CARD NUMBER (HN)</b>		<b>VERSION CODE (VC)</b>	<b>WSIB CLAIM #</b>	<b>OTHER</b> (self-pay, research, 3rd party payor)	
<input type="checkbox"/> <b>INTERPRETER REQUIRED</b> Preferred language		<b>ACCESSIBILITY CONCERNS OR REQUIREMENTS</b>			
<b>ALTERNATE CONTACT (IF NOT PATIENT)</b>	<b>CONTACT NAME</b>			<b>CONTACT PHONE #</b>	

### EXAM INFORMATION AND HISTORY

<b>TEST/REGION(S) TO BE EXAMINED</b>  <input type="checkbox"/> <b>Head</b> <input type="checkbox"/> Brain <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial Bones <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Orbits <input type="checkbox"/> Circle of Willis <input type="checkbox"/> <b>Neck</b> <input type="checkbox"/> Routine <input type="checkbox"/> Carotids  <input type="checkbox"/> <b>OTHER EXAM TYPE</b> (please indicate)	<b>REASON FOR EXAM /CLINICAL HISTORY</b> (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)  <div style="text-align: center; font-size: small;"> <i>If the patient requires emergent attention, do not submit this form to Central Intake. Please contact your nearest imaging facility directly</i> </div> <input type="checkbox"/> <b>TIMED FOLLOW UP</b> <b>DATE REQUESTED</b> (YYYY/MM/DD) <i>CT availability is limited: requested dates will be accommodated where possible.</i>
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### SCREENING & PRECAUTIONS

<b>RENAL ASSESSMENT</b> <input type="checkbox"/> No known kidney issues <input type="checkbox"/> Yes, patient has kidney problems, kidney transplant or is seeing a urologist  If yes, check all that apply: <input type="checkbox"/> Has diabetes <input type="checkbox"/> On dialysis Please provide the most recent eGFR results (within the last 6 months) <b>eGFR RESULT</b> (ml/min/1.73 <sup>2</sup> ) <b>DATE COLLECTED</b> (YYYY/MM/DD)	<input type="checkbox"/> Known hypersensitivity to contrast agents <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Patient cannot provide reliable medical history or provide consent to contrast injections where applicable <input type="checkbox"/> Requires general anesthesia Rationale  <i>For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.</i>
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### PREFERRED LOCATION

All patients will be triaged to the shortest distance unless a preferred location is entered.	<b>PREFERRED LOCATION(S)</b>
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### OTHER ROUTING CONSIDERATIONS

### REFERRING PROVIDER

<b>PROVIDER NAME</b>		<b>BILLING #</b>		<b>PROFESSIONAL ID</b>
<b>ADDRESS</b>			<b>CITY</b>	<b>PROVINCE.</b>
<b>PHONE #</b>	<b>FAX #</b>		<b>COPY TO</b>	
<b>PROVIDER SIGNATURE</b>				<b>DATE</b>

### OFFICE USE ONLY

<b>PRIORITY</b> <input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4	<b>TIMED</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>SPECIFIED DATE</b>
<b>OH</b> <input type="checkbox"/> Cancer <input type="checkbox"/> No	<b>PROTOCOL</b>	<b>RADIOLOGIST</b>