

OUTPATIENT CT REQUISITION FORM

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

EXAM INFORMATION AND HISTORY

TEST/REGION(S) TO BE EXAMINED (Choosing Wisely checklists MUST accompany referrals where appropriate i.e. Spine)	REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)
☐ Head ☐ Brain ☐ Sinuses ☐ Facial Bones ☐ Temporal Bones ☐ Orbits ☐ Circle of Willis ☐ Neck ☐ Routine ☐ Carotids ☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacral/Coccyx ☐ Thorax ☐ Routine ☐ High-resolution ☐ Pulmonary Embolism ☐ Thorax/Abdomen /Pelvis ☐ Abdomen/Pelvis ☐ Routine ☐ Renal Colic ☐ Urography ☐ Enterography ☐ Musculoskeletal (please Indicate) ☐ OTHER EXAM TYPE (please indicate)	☐ TIMED FOLLOW UP DATE REQUESTED (YYYY/MM/DD) <i>CT availability is limited; requested dates will be accommodated where possible.</i>

SCREENING & PRECAUTIONS

RENAL ASSESSMENT ☐ No known kidney issues ☐ Yes, patient has impaired renal function or a history of renal transplant If yes, check all that apply: ☐ Has diabetes ☐ On dialysis Please provide the most recent eGFR results (within the past 3-6 months) eGFR RESULT (ml/min/1.73 ²) DATE COLLECTED (YYYY/MM/DD)	☐ Known hypersensitivity to contrast agents ☐ Currently pregnant ☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable ☐ 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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REFERRING PROVIDER

PROVIDER NAME		BILLING #	PROFESSIONAL ID
ADDRESS		CITY	PROVINCE POSTAL CODE
PHONE #	FAX #	COPY TO	
PROVIDER SIGNATURE			DATE

OFFICE USE ONLY

PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED ☐ Yes ☐ No	SPECIFIED DATE
CCO ☐ Cancer ☐ No	PROTOCOL	RADIOLOGIST