



KINGSTON
GENERAL
HOSPITAL



Religious Hospitallers
of Saint Joseph
of the Hotel Dieu of Kingston
HOTEL DIEU HOSPITAL

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CT REQUISITION

INPATIENT Service: _____

Floor _____ Room # _____ ER _____

Stretcher Wheelchair Walk O₂

Isolation: No Yes/type _____

OUTPATIENT

Clinic CCSEO ER/UCC Other _____

Isolation: No Yes/type _____

Consultation only: Research:

Department of Veterans Affairs ID # _____

WSIB #: _____ Injury Date: _____

Employer: _____

Employer Address: _____

CR#: _____ Female Male

Surname: _____

First Name: _____

Date of Birth: _____

Address: _____

Phone #: (H) _____ (W) _____

Health Card # _____

INCOMPLETE or ILLEGIBLE requisitions will be returned and may DELAY Study

CT EXAMINATION REQUESTED: _____

Clinical Information: _____

Previous related Imaging: No Yes, If yes – where _____

CAUTION: RISKS FOR CONTRAST INDUCED NEPHROPATHY

Blood work is required & must be available at time of appointment for patients with ANY of the following:

	Yes		Yes
Known Renal Dysfunction	<input type="checkbox"/>	If Yes, explain _____	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	On Metformin?	<input type="checkbox"/>
Age greater than 70 Yrs	<input type="checkbox"/>	Volume Contraction, Dehydration	<input type="checkbox"/>
Previous Chemotherapy	<input type="checkbox"/>	Solitary Kidney	<input type="checkbox"/>
Organ Transplant	<input type="checkbox"/>	Sepsis, Acute Hypotension	<input type="checkbox"/>
Cardiovascular Disease (Hypertension, CHF, CAD, PVD)	<input type="checkbox"/>		<input type="checkbox"/>
Nephrotoxic Drugs-Loop Diuretics, NSAIDS, Vancomycin, Aminoglycosides, etc.	<input type="checkbox"/>		<input type="checkbox"/>

PATIENT DOES NOT HAVE ANY ABOVE RISK FACTORS

Creatinine: _____ (µ mol/L) **eGFR:** _____ (mL/minute)

Date Drawn (YYYY/MM/DD): _____

- Outpatients require bloodwork within 60 days of examination date. Inpatients within 7 days or sooner.
- Metformin should be held following IV contrast administration and serum creatinine repeated between 48 and 72 hours after CT and verified before restarting.

Adverse Reaction to contrast: No Yes
If Yes, Explain _____

Possibility of Pregnancy? No Yes

Is patient able to give informed consent? No Yes
If No, please provide written consent.

Ordering Physician Signature: _____

Printed Name & First Initial: _____

Phone / Pager _____

Attending Physician: _____

Copy Report to: _____
(please print name and first initial)

Date requisition complete _____
YYYY/MM/DD

IMAGING USE ONLY

PRIORITY: 1 2 3 4

Protocol: _____

Signature Radiologist/Resident: _____

IV:
 C-
 C+
 C- & C+

Oral:
 Water base
 Water only
 Esophacat
 None
