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

OUTPATIENT ☐

☐ Clinic ☐ CCSEO ☐ ER/UCC ☐ Other _____

Isolation: ☐ No ☐ Yes/Type _____

Consultation only: ☐ Research: ☐

Department of Veterans Affairs ID # _____

WSIB #: _____ Injury Date: _____

CR#: _____ ☐ Female ☐ Male

Surname: _____

First Name: _____

Date of Birth: _____

Address 1: _____

Address 2: _____

Phone # (H) _____ (W) _____

Health Card #: _____

***INCOMPLETE or ILLEGIBLE requisitions will be returned and may DELAY Study***

**CT EXAMINATION REQUESTED:** _____

**Clinical Information**: _____

Reason for scan: ☐ Diagnosis ☐ Surgical Planning ☐ Cancer Staging/Dx ☐ Follow Up

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 | ☐ | If yes, explain _____ | |
| Diabetes Mellitus | ☐ | On Metformin? | ☐ |
| Age greater than 70 Yrs | ☐ | Volume Contraction, Dehydration | ☐ |
| Previous Chemotherapy | ☐ | Solitary Kidney | ☐ |
| Organ Transplant | ☐ | Sepsis, Acute Hypotension | ☐ |
| Cardiovascular Disease (Hypertension, CHF, CAD, PVD) | | | ☐ |
| Nephrotoxic Drugs-Loop Diuretics, NSAIDS, Vancomycin, Aminoglycosides, etc. | | | ☐ |

**PATIENT DOES NOT HAVE ANY ABOVE RISK FACTORS** ☐

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

Date Drawn: (YYYY/MM/DD) _____

1. Outpatients require bloodwork within 60 days of examination date. Inpatients within 7 days or sooner.

2. 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

Name & First Initial: _____

Phone/ Pager _____

Attending Physician: _____

Copy Report to: _____
(Name and first Initial)

Date Requistion Completed: _____
(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
☐ _____