MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

600 University Avenue,
Toronto, Ontario, Canada M5G 1X5

C13 (Rev. 11.2011)

CT Requisition Form

Clearly imprint patient identification card

MODALITY
CT Request Form
SITE AND LOCATION
5th Floor Medical Imaging - Main Reception Desk
TELEPHONE 416-586-4800 x4418
FAX 416-586-3180

PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL BE RETURNED

BIRTHDATE YYYY MM DD

HOSPITAL MEDICAL RECORD NO.

SURNAME

GIVEN NAME

ADDRESS (Street, Apt #)

CITY/TOWN

PROVINCE

POSTAL CODE

TELEPHONE (Area Code & No.)

Health Card Number

Version Code

EXAMINATION(S):

Clinical History and Indications:

The following MUST be completed by the referring physician: (Please check)

1. Does the patient have a history of **Kidney disease**? Yes ☐ No ☐
(eg. 1 kidney, renal failure, dialysis)
2. Is the patient diabetic? Yes ☐ No ☐
3. Previous reaction to IV contrast? Yes ☐ No ☐
4. Does the patient have a pelvic/ileoanal pouch? Yes ☐ No ☐

If YES to question #1 or #2, please provide blood work (must be within the last 3 months)

Creatinine _____ eGFR _____

List Diabetic Medications:

Known Allergies:

IF THE PATIENT HAS A KNOWN CONTRAST ALLERGY, THE REQUESTING PHYSICIAN IS RESPONSIBLE FOR ORGANIZING THE PRE-MEDICATION PRIOR TO THE PATIENTS SCAN. PLEASE FOLLOW THE PRE-MEDICATION INSTRUCTIONS BELOW:

PREDNISONE 50mg P.O 13 HOURS AND 1 HOUR PRE-EXAMINATION
PLUS BENADRYL 50mg P.O 1 HOUR PRE-EXAMINATION.
NOTE: BENADRYL CAN CAUSE DROWINESS. PATIENTS SHOULD MAKE ARRANGEMENTS TO BE DRIVEN TO AND FROM THE EXAMINATION.

REFERRING PHYSICIAN INFORMATION

Name and Initials (Print):

Doctor's Signature: X

Telephone #: ( )

Fax #: ( )

Requested Appointment Date (if applicable):

CPSO #

Mailing Address:

MEDICAL IMAGING USE ONLY	**RADIOLOGIST SIGNATURE:** _____ **RADIOLOGIST NAME (PRINT):** _____	**PROTOCOL:**

MEDICAL IMAGING USE ONLY	**APPOINTMENT DATE** (YYYY MM DD)	**APPOINTMENT TIME (24 hr clock)** (HH:MM)