Request for Cardiac CT Consultation

(Computed Tomography)

HNHB LHIN

Last Name	First Name
HIN/HCN/OHCN/OHIP #	Date of Birth (yyyy/mm/dd)
Address	
City / Province	Postal Code
Phone Number:	Mobile Number:
Gender	Weight (kg) Age

REQUEST TO: **Referral Date:** ____________________

☐ **Hamilton Health Sciences**
Phone: 905-521-2100
Ext: 49600
Fax: 905-527-9053

☐ **St. Joseph's Healthcare (Hamilton)**
Phone: 905-521-6074
Ext: 36009
Fax: 905-540-6588

☐ **Niagara Health**
Phone: 905-378-4647
Ext: 46391
Fax: 905-684-6990

Please attach a consult note with relevant cardiac and medication history.

Referring Physician: ______________________________ (Printed Name) ______________________________ (Signature & Designation) Unit: ____________ Phone: ______________

Hospital/Other Facility: ________________________ Phone: ____________________ Fax: ________________________________

Primary Care Physician: ________________________ Phone: ____________________ Fax: ________________________________

Send Additional Report to: ☐ Primary Care Physician ☐ Other: ____________________ (Printed Name) ____________________ (Phone Number) ____________________ (Fax)

Preferred Physician ______________________________

Current Patient Location:
- ☐ Inpatient: ____________
- ☐ Outpatient

Exam Indication(s):
- ☐ Suspected CAD
- ☐ TAVI Assessment
- ☐ Bypass Graft Assessment
- ☐ Pre or Post Pulmonary Vein Ablation
- ☐ Cardiac Surgery Planning (please indicate procedure):

____

☐ Surgery/procedure scheduled? **YES / NO**

DATE (if applicable): ________________________________

Other: ____

Relevant Clinical History:

EKG details: Attach the most recent EKG

Please answer all of the following questions:

1) Known Renal Disease? **YES / NO**
2) Known Diabetes? **YES / NO**
3) On Metformin? **YES / NO**

If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:

eGFR:________ ml/min/1.73^2 Date: _________________ (yyyy/mm/dd)

Creatinine:________ ml/min/1.73 Date: _________________ (yyyy/mm/dd)

4) Known Contrast Allergy?

If yes, has the patient been provided with the pre-medication instructions listed below:
- ☐ Prednisone **50 mg** PO 12 hours and 2 hours pre-procedure
- ☐ Diphenhydramine **50 mg** PO/IV 1 hour pre-procedure

Does the patient have any of the following contraindication(s) to:
- ☐ Metoprolol **YES / NO**
  (ex. Allergies, severe asthma, 2nd/3rd degree heart block, severe aortic stenosis etc.)
- ☐ Nitroglycerin **YES / NO**
  (ex. Allergy, on PDE inhibitor such as Viagra or Cialis)

Beta Blocker Premedication Protocol

Give beta blocker naive patients the following doses of Metoprolol:
- ☐ **50 mg** the **day before** at 1600 (4pm)
- ☐ **50 mg** the **night before** the scan
- ☐ **50 mg one hour before** the scan

For patients already on beta blockers: adjust as per clinical judgement

If the patient's own intrinsic Heart Rate is < 65 then NO Beta Blocker is required. Details:

FOR CT USE ONLY

Reviewed by: ______________________ (Printed Name) (Signature & Designation) ______________________ Date: ____________________ (yyyy/mm/dd)

Priority: 1 2 T2 3 T3 4 T4 Test Date: ______________________ (yyyy/mm/dd) Test Time: ____________________ (hh:mm)

Protocol: ______________________________________ (Date Protocolled: (yyyy/mm/dd)) Radiologist (printed): ______________________

Additional Comments: ______________________________________ Signature: ______________________