Ontario Health West

HOSPITAL ID: _____

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, email

SEX ASSIGNED AT BIRTH	GENDER IDENTITY	D.O.B. (YYYY/MM/DD)	HEIGHT (CM)	WEIGHT (KG)
☐ Female ☐ Male	☐ Female ☐ Male ☐ Other			

HEALTH CARD #	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

☐ **HEAD**
☐ 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)

REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)

☐ TIMED FOLLOW UP	DATE REQUESTED (YYYY/MM/DD)

CT availability is limited; requested dates will be accommodated where possible.

SCREENING AND 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 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:

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.

REFERRING PROVIDER

PROVIDER NAME	BILLING #	PROFESSIONAL ID

ADDRESS	CITY	PROVINCE	POSTAL CODE

PHONE #	FAX #	COPY TO

PROVIDER SIGNATURE	DATE

HOSPITAL LOCATION – MUST BE SELECTED

Select the hospital you would send this patient to, given their diagnostic imaging requirements. **Patient will be directed to reasonable nearest hospital with lowest wait times:**

☐ Alexandra Marine and General Hospital
☐ Bluewater Health
☐ Brant Community Healthcare System
☐ Brightshores Health System
☐ Cambridge Memorial Hospital
☐ Chatham-Kent Health Alliance
☐ Erie Shores Healthcare
☐ Guelph General Hospital
☐ Haldimand War Memorial Hospital
☐ Hamilton Health Sciences
☐ Hanover and District Hospital
☐ Huron Perth Healthcare Alliance
☐ Joseph Brant Hospital
☐ Listowel Wingham Hospital Alliance
☐ London Health Sciences Centre
☐ Niagara Health System
☐ Norfolk General Hospital
☐ South Bruce Grey Health Centre
☐ St Joseph's Health Care - London
☐ St Joseph's Healthcare - Hamilton
☐ St Thomas-Elgin General Hospital
☐ Strathroy Middlesex General Hospital
☐ Tillsonburg District Memorial Hospital
☐ Waterloo Regional Health Network
☐ Wellington Health Care Alliance
☐ Windsor Regional Hospital
☐ Woodstock Hospital

☐ **Patient must go to selected hospital. This may result in longer wait times.**

OFFICE USE ONLY

PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED ☐ YES ☐ NO	SPECIFIED DATE

CCO	PROTOCOL	RADIOLOGIST