Cardiac CT Requisition

SHN SCARBOROUGH HEALTH NETWORK

Centenary Hospital
2867 Ellesmere Road
Scarborough, ON M1E 4B9

Telephone
416- 431-8167

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416-431-8141

Patient Name _____
Last First

Date of Birth _____
D M Y

Health Card _____ **Version**_____

Address_____

City _____ **Postal Code** _____

Telephone **Home** (_____) _____

Business (_____) _____

Cell (_____) _____

☐ **CT Angiography (with Calcium Score)**

☐ **Calcium Score Only**

☐ **Pulmonary Vein Study**

☐ **CABG Study**

Appointment:

Indication for Exam:

History of Allergy to IV Contrast: ☐ **Yes** ☐ **No If yes type of reaction:** _____ **Patient weight** _____ **kg**

Intolerance to Beta Blockers: ☐ **Yes** ☐ **No** **On Chronic Beta Blockers :** ☐ **Yes** ☐ **No** **On Diltiazem:** ☐ **Yes** ☐ **No**

Clinical Profile		Risks for Contrast Nephropathy	
CABG	☐ Yes ☐ No Date:_____	≥ 60 years of age	☐ Yes ☐ No
Coronary stent	☐ Yes ☐ No Date:_____	Diabetes	☐ Yes ☐ No
Prior myocardial infarction	☐ Yes ☐ No	Hypertension requiring medication	☐ Yes ☐ No
Family history of premature CAD	☐ Yes ☐ No	Any other kidney problem (e.g. nephropathy, transplant, single kidney, surgery, cancer, dialysis)	☐ Yes ☐ No
Smoker	☐ Yes ☐ No	If **YES** to any of the above provide: Creatinine: _____ eGFR:_____ Test date: _____ ☐ Pending	
On lipid lowering therapy	☐ Yes ☐ No		
Severe aortic stenosis	☐ Yes ☐ No		
Chronic atrial fibrillation	☐ Yes ☐ No		
HOCM	☐ Yes ☐ No		

Symptoms: ☐ Typical chest pain ☐ Atypical chest pain ☐ Dyspnea ☐ Other_____ ☐ None

Prior Stress: ☐ Nuclear ☐ Stress echo ☐ Graded exercise test ☐ None

Ethnicity: ☐ Caucasian ☐ Black ☐ South Asian ☐ Asian ☐ Middle eastern ☐ Other_____

PHYSICIAN INSTRUCTIONS:

- If patient is not already on chronic beta blockers or Diltiazem , then prescribe BISOPROLOL 5 mg to be taken for 5 days (inclusive of the CT scan day)
- If patient is prone to anxiety, please prescribe LORAZEPAM 1 mg 30 minutes prior to CT scan
  *** Patient will require someone to drive them home****
- Instruct patient to abstain from VIAGRA®, LEVITRA®, or CIALIS® for 72 hours prior to the test

Referring Physician	**Copies to:**
Phone # **Fax#**	
Physician Signature	**Date**

Please fax this completed form, along with most recent ECG, and bloodwork if required
INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED

Form ID: 2108

2108