SHN
SCARBOROUGH HEALTH NETWORK

Request for CT

☐ Outpatient ☐ Inpatient ☐ ED | loc. _____

☐ **BIRCHMOUNT**
3030 Birchmount Road
Scarborough, ON M1W 3W3

☐ **CENTENARY**
2867 Ellesmere Road
Scarborough, ON M1E 4B9

☐ **GENERAL**
3050 Lawrence Ave East
Scarborough, ON M1P 2V5

PHONE 416-431-8167 **FAX** 416-431-8141

Outpatient requests will be given first available at any department unless specified

PATIENT INFORMATION

Name _____ *Last name, First name*
Date of birth _____ *Day-Month-Year* Sex ☐ F ☐ M ☐ Other

Health card _____ Version code _____ Hospital ID _____

Address _____

City _____ Postal code _____ Phone 1 _____ *Preferred* Phone 2 _____ *Alternate*

TEST/REGION TO BE EXAMINED

☐ Head ☐ CTA PE ☐ CTA carotids
☐ Neck ☐ HRCT chest ☐ Trauma c-spine
☐ Chest ☐ Hematuria (triphasic) ☐ Sinuses
☐ Abdomen/pelvis ☐ CT enterogram ☐ Facial bones
☐ Renal colic ☐ Ischemic bowel ☐ Temporal bones

Other:

CLINICAL INDICATION/RELEVANT HISTORY

Relevant previous imaging reports must be attached

INTERNAL DI USE ONLY

Priority ☒ 1 ☐ 2 ☐ 3 ☐ 4 | ☒ Timed
CCO ☒ Cancer ☒ Other

Rad _____

SCREENING

NEPHROPATHY

Age > 60 ☐ Y ☐ N
Diabetes ☐ Y ☐ N
Hypertension requiring medication ☐ Y ☐ N
Renal transplant or single kidney ☐ Y ☐ N
Renal surgery or renal cancer ☐ Y ☐ N
Dialysis ☐ Y ☐ N

If any nephropathy risk factor, provide:

eGFR _____ Test date (< 6 wks) _____ *Day-Month-Year*

PRECAUTIONS

Patient weight _____ kg
Chance of pregnancy ☐ Y ☐ N
Allergy to IV contrast ☐ Y ☐ N

If prior mild or moderate adverse reaction,
referring physician to provide premedication for contrast studies:
PREDNISONE 50 mg PO 13 h and 1 h before exam
DIPHENHYDRAMINE (e.g. BENADRYL) 50 mg PO 1 h before exam

BILLING

☒ OHIP ☒ WSIB claim # _____ ☐ Other _____

REFERRING PHYSICIAN

Name, address, fax, phone, billing number:

Send copies to:

Signature ✗ _____ Date _____

Incomplete or unsigned requests will be returned and may result in delay