Ontario
South West Local Health Integration Network

Choosing Wisely Canada

CT REQUISITION – this form can be found on www.swpca Check one Site:

☐ Alexandra Marine and General Hospital-Goderich	F: 519-524-8532	☐ Middlesex Hospital Alliance - Strathroy	F: 519-246-5930
☐ Grey Bruce Health Services - Owen Sound	F: 519-376-3952	☐ South Bruce Grey Health Centre -Walkerton	F: 519-881-1388
☐ Hanover and District Hospital	F: 519-364-0062	☐ St. Joseph's Health Care London	F: 519-646-6204
☐ Huron Perth Health Care Alliance - Stratford	F: 519-272-8247	☐ St. Thomas Elgin General Hospital	F: 519-631-8842
☐ Listowel Memorial Hospital	F: 519-291-2813	☐ Tillsonburg District Memorial Hospital	F: 519-842-4299
☐ LHSC – UH	F: 519-663-3034	☐ Woodstock Hospital	F: 519-421-4238
☐ LHSC – VH / Children's	F: 519-667-6826		

PATIENT INFORMATION:

Surname: ______________ First Name: ______________ Middle Initial: ________

Gender: ☐ M ☐ F ☐ X Date of Birth (YYYY-MM-DD): ______________

Street Address: ______________ Apt: ____ City: ______________ Province: ________ Postal Code: ________

Health Card No. : ______________ Version Code: ______ Research or 3rd Party No.: ______________

Telephone (Day): ____________ (Evening): ____________ (Cell): ____________

☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ ED

WSIB: ☐ Y ☐ N ________ WSIB No.: ____________ Date of Injury (YYYY-MM-DD): ____________

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ☐ EN ☐ OTHER ______________

Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric ☐ Interpreter Required

Y N Please check the following:

☐ ☐ Allergic to radiographic contrast
☐ ☐ Pregnant ____ wks.
☐ ☐ Heparin Flush Ordered
☐ ☐ Power PICC
☐ ☐ CT Porta Cath
☐ ☐ History of Cancer

Precautions

☐ TB ☐ MRSA
☐ VRE ☐ Shingles

***** If yes to any of the risk factors please draw creatinine levels***

Y N Contrast Risk Factors:

☐ ☐ Diabetic
☐ ☐ On dialysis
☐ ☐ History of impaired renal function or Nephrectomy
☐ ☐ Patient > 70 yrs old
☐ ☐ On any diabetic medications: ______________
☐ ☐ Hypertension
☐ ☐ Medications/conditions predisposing to nephrotoxicity
☐ ☐ Other: ______________

☐ Y ☐ N Related surgery
☐ Y ☐ N Urgent
☐ Y ☐ N Routine
☐ Y ☐ N Timed ______
☐ Y ☐ N Cancer
☐ Y ☐ N Staging/ Followup
______ Timing of above

Please attach previous imaging and reports (ie ECG)

REFERRING PHYSICIAN:

Name ______________ Address: ______________

City: ____________ Postal Code: ________ Tel: ________ FAX: ________

Physician's Signature: ______________ CPSO No: ____________

Copy to: ______________

Serum Creatinine (must be drawn within the past 3 months)

Result: ____________

eGFR: ____________

Sample date: ____________

Height: cm/in. ____________

Weight: kg/lbs. ____________

EXAMINATION REQUESTED:

WORKING DIAGNOSIS:

CLINICAL INFORMATION:

OFFICE USE ONLY	FOR TECHS/RADS	FOR BOOKING STAFF
Protocol: ☐ Water Prep ☐ Barium ☐ Water Soluble ☐ Enterography Prep ☐ IV ☐ Rectal ☐ Non Contrast ☐ without and check ☐ Nitro ☐ Beta Blockers ☐ Hyoscine (Buscopan) ☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed: ________ Staff Initials: ________		**Appointment Date:** **Arrival Time:**

NOTE: This requisition may be booked at an alternate site in the South West LHIN to improve patient access.