SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

DEMOGRAPHIC LABEL

REQUEST FOR CT SCAN

Bookings: Telephone: 705-759-3642 Fax: 705-759-3714
Can the CT department leave a message on patient's answering machine about their appointments? ☐ Yes ☐ No
Number If Yes:_____

☐**In Pt Room #**_____ ☐**Emergency Pt** ☐**Out Pt**

Physician Information
Name (Print): _____
Signature: _____

Third Party / Insurance
WSIB
Claim Number _____
Date of Injury _____
Employer's Name and Address _____
_____

EXAMINATION REQUESTED _____
CLINICAL INFORMATION

_____

All of the following questions must be completed before the CT will be booked. (**Please check Yes/No**)

1. a) Is the patient allergic to radiographic IV contrast? ☐ Yes ☐ No
   b) What type of reaction? _____
2. a) Is the patient over 60 years old? ☐ Yes ☐ No
   b) Is the patient taking Metformin or any of its derivatives?? ☐ Yes ☐ No
   c) Is there a history of renal impairment or nephrectomy? ☐ Yes ☐ No
   d) Is the patient currently on dialysis? ☐ Yes ☐ No
   e) Does the patient have other medical conditions or take any medications that may predispose them to nephrotoxicity; hypertension medication, multiple myeloma? ☐ Yes ☐ No

Date of last menstrual period: _____

IF YOU HAVE ANSWERED YES TO ANY OF THE ITEMS IN QUESTION#2, A RECENT CREATININE (1 MONTH) MUST BE FORWARDED WITH THE REQUISITION. THE PATIENTS WEIGHT MUST ALSO BE INCLUDED. CT APPOINTMENTS WILL NOT BE BOOKED WITHOUT THESE TWO VALUES

Creatinine: _____ Date: _____

Patient's Weight: _____ pounds/Kgs egfr: _____

FOR DIAGNOSTIC USE ONLY

Date received: Exam codes: _____
Technologist comments:

Radiologist Priority 1◯ 2◯ 3◯ 4◯ ENITS ☐

Radiologist instructions:_____
_____

APPOINTMENT DATE AND TIME: _____