SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

Request for Cardiac CT Angiogram

Thank you for referring your patient for a Cardiac CT Angiogram. Please complete this form. Fax to the Cardiac Care Services 705-759-3609

Please note our referral process has changed for Cardiac CTs. All referrals will be reviewed and triaged by a Cardiologist before being booked through Diagnostic Imaging. A CTA will NOT be performed if the patient's BMI is over the maximum required to complete the test.

The following may be a contraindication to a Cardiac CT: ☐ **Calcium Score only** ☐ **URGENT** ☐ **NON-URGENT**

- arrhythmias, e.g., atrial fibrillation, bigeminy, trigeminy
- a high heart rate which cannot be controlled with Beta-blockers or calcium channel blockers
- allergy to X-ray contrast with failed steroid prep
- renal insufficiency in patients not on dialysis
- inability to breath hold for 15 seconds
- pacemakers and implanted defibrillators
- **BMI greater than 45KG/M2**

If a patient has any of the above, please notify the Cardiologist for further discussion.

Beta-blockers:
These are usually required for a Cardiac CT to slow the heart rate to less than 60 bpm.

- **What is the patient's resting HR?** _____**bpm**
- Is the patient on Beta-blockers? ☐ Yes ☐ No

Reason for cardiac CT referral: _____

Please list the patient's cardiac medications: _____

IMPORTANT INSTRUCTIONS:

If the patient has diabetes or impaired renal function, you must submit eGFR results done within 1 months of the CT appointment. For all Trans Aortic Valve Implantation (TAVI) requests, eGFR is mandatory. Submit all surgical reports available.

Patient's height: _____ **Patient's weight (MAX BMI 45KG/M2):** _____

Creatinine _____**eGFR** _____ **Date of labs:** _____

History of allergic reaction to IV contrast in the last 10 years? If yes, please describe (hives, cardiorespiratory arrest) _____

_____

☐ **Approved** ☐ **Not Approved** **Approved by:** _____ **Date:** _____
(Cardiologist)

Rationale for not approved: _____

REFERRING HEALTHCARE PROVIDER

Provider's Name: _____ Telephone: _____

Billing #: _____ Fax: _____ CPSO Number: _____

Provider's Signature: X _____ Date: _____ DD/MM/YYYY

INCOMPLETE/ILLEGIBLE REQUESTS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT.
FORM MUST BE COMPLETE, INCLUDING CLINICAL & SAFETY INFORMATION AND PROVIDER SIGNATURE.