

Diagnostic Imaging Requisition CT Scanning or Special Procedures

Hospital Unit #: _____ Mississauga Booking: (905) 848-7554 West Toronto Booking: (416) 521-4069 Mississauga Fax: (905) 804 -7926 West Toronto Fax: (416) 521-4014

IMPORTANT NOTICE: A booking will <u>not</u> be made for any CT examination unless <u>all</u> sections of this form are completed by the Referring Physician. If the test is being requested based on abnormalities found on an Imaging study performed outside of Trillium Health Centre, the relevant mages/films/reports MUST accompany this requisition. The requisition <u>must be completed and signed by the physician</u>.

Office Use Only: Date Requisition Received: Appointment Date: DD	Please arrive 15 minutes prior to your appointment time to allow for registration				
Appointment Date:			Diagnostic Imaging Protocol Use Only		
Site patient pregnant? Yes No Contrast Media No Yes No Contrast Media No Yes No No Yes No No Yes No No Yes No No No No No No No N					
Contrast Media No Yes Amount Given: ml Given By (Initials): Several Patient Name: Date of Birth: Date of Bi			Is the patient pregnant? Yes No		
Patient Name:			Contrast Media No Yes		
LASTNAME	☐ Mississauga ☐ West Toronto		Amount Given: ml Given By (Initials):		
Patient Weight: (table capacity is 400 lb) Health Card No:					
Nealth Card No.:			RST NAME MM /	DD / YYYY	
Address: City: Postal Code: Home Phone: (
Note				Female	
Exam Requested: Arthrogram CT Scan Myelogram Nerve Root Injection (state region) P.I.C.C. Line Insertion Other, Please specify: Area of Interest: Clinical Information: Previous Imaging Studies (Please attach report): Allergy to medication? No Yes, please state: Allergy to I.V. Contrast Media containing Iodine? No Yes If Yes', any prescription The patient Will be given an information sheet after the examination. Where possible please complete the following: Referring Physician: Do you require the services of an interpreter? Yes No Yes Is the patient subject to claustrophobia? Is the patien			City: Postal Code:		
Facet Block (state region) Myelogram Nerve Root Injection (state region) P.I.C.C. Line Insertion					
Clinical Information:			_		
Area of Interest: Clinical Information:					
Clinical Information: Previous Imaging Studies (Please attach report):	Uther, Please specify:				
Previous Imaging Studies (Please attach report): Na	Area of Interest:				
Previous Imaging Studies (Please attach report): Na					
Nuclear Medicine CT Scan Other Is the Patient Diabetic? No Yes If Yes', any prescription for Metformin must be discontinued for 48 hrs after a contrast-enhanced examination. Where possible please complete the following: Referring Physician: BUN Creatinine Yes No Phone: () OHIP Billing Number: Is the patient subject to claustrophobia? I I Physician: Performing Technologist: Please send copies to: Physician:	Clinical Information:				
Nuclear Medicine CT Scan Other Is the Patient Diabetic? No Yes If Yes', any prescription for Metformin must be discontinued for 48 hrs after a contrast-enhanced examination. Where possible please complete the following: Referring Physician: BUN Creatinine Yes No Phone: () OHIP Billing Number: Is the patient subject to claustrophobia? I I Physician: Performing Technologist: Please send copies to: Physician:					
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Nuclear Medicine	Previous Imaging Studies (Please attach report)	:	Allergy to medication? No Yes, please state:		
Results: Metformin must be discontinued for 48 hrs after a contrast-enhanced examination. The patient will be given an information sheet after the examination. Where possible please complete the following: Referring Physician: Address: Do you require the services of an interpreter? Phone: () OHIP Billing Number: Fax: () Performing Technologist: Please send copies to: Physician: Physician: Address: Address: Address:			Allergy to I.V. Contrast Media containing Iodine? No Yes		
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INCOMPLETE AND OP UNSIGNED PROHISTIONS WILL BE DETUDNED					

Revised: Apr. '08 Form: 7-364