Trillium HEALTH CENTRE

# 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 not be made for any CT examination unless all 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 **must be completed and signed by the physician.**

**Please arrive 15 minutes prior to your appointment time to allow for registration**

**Office Use Only:**
**Date Requisition Received:** _____

**Appointment Date:** _____ / _____ / _____
DD MM YYYY

**Time:** _____

☐ Mississauga ☐ West Toronto

**Diagnostic Imaging Protocol Use Only**

**Is the patient pregnant?** ☐ Yes ☐ No
**Contrast Media** ☐ No ☐ Yes
**Amount Given:** _____ **ml** **Given By (Initials):** _____

**Patient Name:** _____ **Date of Birth:** _____
LAST NAME FIRST NAME MM / DD / YYYY

**Patient Weight:** _____ (table capacity is 400 lb)

**Health Card No.:** _____ **Version Code:** _____ **Sex:** ☐ Male ☐ Female

**Address:** _____ **City:** _____ **Postal Code:** _____

**Home Phone:** ( ) **Work Phone:** ( )

**Exam Requested:** ☐ Arthrogram ☐ CT Scan
☐ Facet Block (state region) ☐ 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) :
☐ X-Ray ☐ Ultrasound ☐ MRI
☐ Nuclear Medicine ☐ CT Scan ☐ Other
**Results:** _____

**Allergy to medication?** ☐ No ☐ Yes, please state: _____
**Allergy to I.V. Contrast Media containing Iodine?** ☐ No ☐ Yes
**Is the Patient Diabetic?** ☐ No ☐ Yes If 'Yes', any prescription for Metformin must be discontinued for 48 hrs after a contrast-enhanced exam.
The patient will be given an information sheet after the examination.
Where possible please complete the following:
BUN _____ Creatinine _____

**Referring Physician:** _____
**Address:** _____
**Phone:** ( ) _____ **OHIP Billing Number:**
**Fax:** ( ) _____

| | Yes | No |
|---|---|---|
| Do you require the services of an interpreter? | [ ] | [ ] |
| Is the patient subject to claustrophobia? | [ ] | [ ] |

**PHYSICIAN SIGNATURE:**

**Performing Technologist:** _____

**Please send copies to:**
**Physician:** _____
**Address:**

**Please send copies to:**
**Physician:** _____
**Address:**

**INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED**