ST. MICHAEL'S
UNITY HEALTH TORONTO

Medical Imaging
30 Bond Street, Toronto, ON, M5B 1W8
3rd Floor, Cardinal Carter Wing
Website- http://bit.ly/2ucQCPA

CT Requisition

Fax 416-864-3019
Tel. 416-864-5656

APPOINTMENT
Exam Date: _____
Arrival Time: _____
Exam Time: _____

A. PATIENT INFORMATION

MRN **DOB** *YYYY/MM/DD*

Health Card #: _____ **VC:** _____

Last Name

First Name

Street Address

City **Postal Code**

Province **Country**

☐ **Interpreter: Language** _____

☐ **Restricted Mobility, Please describe needs** _____

☐ **Isolation** _____

☐ **Self Pay** ☐ **IFH** ☐ **WSIB Claim #:** _____

☐ **Female** ☐ **Male** ☐ **Intersex**

☐ **Transgender - Female to Male**

☐ **Transgender - Male to Female** ☐ **Please Specify** _____

Patient Consents to leave message ☐ **Yes** ☐ **No**

MOBILE: _____

HOME: _____

WORK: _____

REQUIRED PATIENT INFORMATION

Pregnancy ☐ Yes ☐ No Weight: _____kg Height:_____cm

B. EXAM INFORMATION

EXAM REQUESTED: **DATE OF REQUEST:** *YYYY/MM/DD*

CLINICAL INFORMATION:

C. MEDICAL HISTORY **MANDATORY FOR ALL CONTRAST CT EXAMS - INCOMPLETE REQUESTS WILL BE RETURNED**

If YES to any of the questions below, a serum Creatinine/eGFR (completed within 60 days prior to appointment) MUST be provided to avoid delays or cancellations.

1. Is the patient 70 years or older? ☐ YES ☐ NO
2. Is the patient diabetic? ☐ YES ☐ NO
3. Is the patient on Metformin? ☐ YES ☐ NO
4. Does the patient have a history of kidney dysfunction? ☐ YES ☐ NO
5. Does the patient have a single kidney? ☐ YES ☐ NO
6. Is the patient on hemodialysis? ☐ YES ☐ NO
7. Does the patient have a continuous glucose monitor? ☐ YES ☐ NO

Does the patient have HHT or history of Pulmonary AVMs?
☐ **Yes** ☐ **No**

Please list all allergies:

CREATININE: _____ **eGFR:** _____

BLOODWORK DATE: *YYYY/MM/DD* _____

CONTRAST ALLERGY

Is the patient allergic to iodinated IV contrast media? (CT dye/IVP dye)
☐ No ☐ Yes
* if yes please provide your patient with the medication as described here →

Pre-medication Instructions for Contrast Allergy
1. Prednisone 50mg PO - 13hrs, 6 hrs and 1 hour pre-CT exam
2. Benadryl 50mg PO - 1 hour pre-CT exam

C. ORDERING PHYSICIAN INFORMATION & SIGNATURE

Ordering Physician Name (please print):

Copy to
(please print):

Signature: Date:

CPSO # : Billing #

Fax # : Phone #

Form No. 74001 Rev. Apr14_2020