Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING– **CT**

Tel: 613-354-3301 x263

Patient Name:

DOB:
HCN:
Address:

Phone/Cell #:

WSIB #:

[Affix patient label here]

Physician Name: _____

Physician Signature: _____

Physician Contact #: _____

Date of Referral: _____

Report Copies To: _____

Message capable Physician phone # to receive same/next exam day urgent results:

_____ **(required)**

. INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .
PLEASE FAX COMPLETED REQUISITION TO 613-354-4331

☐ ER Patient in Hospital ☐ ER Patient Sent Home ☐ Inpatient/ICU ☐ CVC Outpatient ☐ Outpatient

BODY PART(S) TO BE IMAGED:_____

CLINICAL INDICATION:

Requested date/time frame: _____

Note: DI Department triages requests based on provided history

P1 = Within 24hr **P3** = Within 10 days = **P3c Oncology**

P2 = Within 48hr **P4** = Within 28 days = **P4c Oncology**

NECESSARY Information (Circle & Fill In Blanks):

1) **IS eGFR REQUIRED FOR CONTRAST EXAM? Y* / N**
***YES only** if patient: 1) Age >70; 2) Has Chronic Renal Dysfunction or Solitary Kidney; 3) Hypertensive requiring medication; 4) Diabetic.

****PLEASE FAX eGFR RESULTS ALONG WITH REQUISITION**

****eGFR results must be** < 6 months for outpatients (P3/P4)
< 7 days for inpatients (P2)
Same day for acutely ill patients

2) **IS THE PATIENT ON HEMODIALYSIS? Y / N**
***If Yes,** exempt from eGFR requirements

3) **CAN THE PATIENT GIVE INFORMED CONSENT? Y / N**
***If NO**, written consent provision required

4) **KNOWN CONTRAST ALLERGY? YES* / NO**
***YES** (Circle & Specify Below) **=**

i. **Minor Reaction** (ie. Hives, Itchy) _____
***** DI department can suggest a prophylactic medication regimen for prior Minor Reaction patients by fax. The administration of such prophylaxis is the responsibility of the referring physician.

ii. **Major Reaction** (ie. Anaphylaxis) _____
***** Non contrast exam only performed.

5) **PATIENT WEIGHT** _____ **lbs/kg**
CT table weight restriction: 500 lbs/225kg

Note: Oral Contrast is not required/ routinely administered.

Appointment Date: **(DD/MM/YY) Time:** **Date Received:** **Date Notified:**