



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:**