Brockville General Hospital

CT COLONOGRAPHY (CTC) REQUISITION

PLEASE FAX COMPLETED REQ TO 613-345-8324

As of April 2018

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Phone Number: _____ Health Card #: _____ VC: _____

PLEASE NOTE: The table weight limit is 180 kg (400 lbs); heavier patients will not be booked.

PLEASE INFORM THE PATIENT THAT BOWEL PREPARATION IS CRITICAL AND THAT A RECTAL TUBE WILL BE USED FOR THIS EXAMINATION

Study Requested: ☐ Screening Colonography ☐ Completion of incomplete OC (if same day request you MUST call the Radiologist).

Clinical Information: Please note that the objective of CTC is colonic cancer screening and completion of incomplete optical colonoscopies. PLEASE PROVIDE MOST RECENT OPTICAL COLONCOSOCOY (OC) REPORT WITH THIS REQUISITION.

The following must be completed for all CTC requests:

Patient weight: _____lbs (table limit is 400 lbs)

Prior Optical Colonoscopy (OC)? Yes ☐ No ☐ Date: _____

Bowel Surgery < 6 weeks? Yes ☐ No ☐ Date: _____

Colonic Biopsies < 6 weeks? Yes ☐ No ☐ Date: _____

Deep? Yes ☐ No ☐ Date: _____

Superficial? Yes ☐ No ☐ Date: _____

Polypectomy < 6 weeks? Yes ☐ No ☐ Date: _____

Active colitis/acute abdominal disease? Yes ☐ No ☐ Date: _____

Personal history of colorectal cancer? Yes ☐ No ☐

If YES to any of the above, dates must be provided.

Ordering Provider Name: _____ (Please print)

Ordering Provider Signature: _____(Print and sign) **Date:** _____

Diagnostic Imaging Use Only:

Protocol: _____ **Protocolled by:** _____

Priority: 1 2 3 4

Date: _____ **Time:** _____ **Confirmed:** _____