Brockville General Hospital

# CT REQUISITION

**PLEASE FAX COMPLETED REQ TO 613-345-8324**

**As of July 2021**

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

Address: _____ City: _____ Postal Code: _____

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

If WSIB – Claim # _____ Date of Injury: _____

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**PLEASE NOTE: The table weight limit is 270 kg (600 lbs); heavier patients will not be booked.**

**Specific Area to be Scanned:** _____

**Clinical Information:**

| | |
|---|---|
| Patient weight: _____lbs (table limit is 270 kg)<br>Prior relevant surgeries: _____<br>_____<br>_____<br>Pregnant? Yes ☐ No ☐<br>Smoker? Yes ☐ No ☐<br>Previous adverse IV contrast reactions? Yes ☐ No ☐<br>If yes, specify: _____ | Age over 70? Yes ☐ No ☐<br>Chronic renal dysfunction or solitary kidney? Yes ☐ No ☐<br>Hypertension requiring medication? Yes ☐ No ☐<br>Diabetic? Yes ☐ No ☐<br>If YES to any of the above, serum creatinine and eGFR are required for IV contrast studies (within ≤ 6 months for stable outpatients, ≤ 7 days for inpatients and same day for acutely ill, Emergency and ICU patients).<br>Creatinine (umol/L): _____<br>eGFR: _____<br>Date of Bloodwork: _____ |

**Ordering Provider Name**: _____ (Please print)

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

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**Diagnostic Imaging Use Only:**

**Protocol:** _____ **Protocolled by:** _____

| **IV** | **ORAL** |
|---|---|
| ☐ **C-** | ☐ **Water Based** |
| ☐ **C+** | ☐ **Water Only** |
| ☐ **C- & C+** | ☐ **None** |
| ☐ **Pre-Med** | ☐ **Enterography** |

**Priority: 1 2 3 4**

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