Brockville General Hospital

CT REQUISITION

PLEASE FAX COMPLETED REQ TO (855) 565-6465

As of August 2025

PATIENT INFORMATION

Last Name	First Name	Date of Birth	YYYY	MM	DD

Address	City	Postal Code

Phone	E-mail Address	Health Card Number	Ver Code

If WSIB – Claim # _____ **Date of Injury** (YYYY/MM/DD):_____/____/____

CLINICAL INFORMATION

Select body region(s) to be scanned:

Head ☐ **Neck** ☐ **Chest** ☐ **Abdomen** ☐ **Pelvis** ☐ **Spine** **Cervical** ☐ **Thoracic** ☐ **Lumbar** ☐ **Upper Ext** ☐ **Lower Ext** ☐

Other:_____

Clinical Information:

Patient weight: _____lbs

(Please note that table limit is 270 kg/600 lbs. Patients over this limit will not be booked)

Prior relevant surgeries: _____

_____

_____

Pregnant? Yes ☐ No ☐

Smoker? Yes ☐ No ☐

Previous adverse IV contrast reactions? Yes ☐ No ☐

If yes, specify: _____

Do you have kidney problems or a kidney transplant? Yes ☐ No ☐

Have you seen, or are you waiting to see a kidney specialist or urologist (kidney surgeon)? Yes ☐ No ☐

If YES to either of the questions above, an eGFR is required for IV contrast studies (within less than or equal to 6 months for outpatients, less than or equal to 7 days for inpatients and same day for acutely ill, Emergency and ICU patients).

eGFR: : _____

Date of Bloodwork: _____

CLINICIAN INFORMATION

Date of the Request (YYYY/MM/DD): _____/____/____

Requesting Clinician Name (PRINT First and Last Name)	Clinician Fax Number
Clinician Signature	**Clinician Phone Number**

REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE

Copy Report to (PRINT First and Last Name)	Copy to Fax Number

DIAGNOSTIC IMAGING USE ONLY

Protocol: _____ **Protocolled by:** _____

IV
- ☐ **C-**
- ☐ **C+**
- ☐ **C- & C+**
- ☐ **Pre-Med**

ORAL
- ☐ **Water Based**
- ☐ **Water Only**
- ☐ **None**
- ☐ **Enterography**

Priority: 1 2 3 4

Date (YYY/MM/DD): _____/____/____ **Time:** _____ **Confirmed:** _____