Brockville General Hospital

CT COLONOGRAPHY (CTC) 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

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

PLEASE NOTE: The table weight limit is 270kg (600 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

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 600 lbs)

Prior Optical Colonoscopy (OC)?	☐ Y	☐ N	Date: _____
Bowel Surgery less than 6 weeks?	☐ Y	☐ N	Date: _____
Colonic Biopsies less than 6 weeks?	☐ Y	☐ N	Date: _____
☐ Deep?		☐ Superficial	
Polypectomy less than 6 weeks?	☐ Y	☐ N	Date: _____
Active colitis/acute abdominal disease?	☐ Y	☐ N	Date: _____
Personal history of colorectal cancer?	☐ Y	☐ N	**If YES to any of the above, dates must be provided.**

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:** _____

Priority: 1 2 3 4

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