Ontario Health West

HOSPITAL ID: _____

OUTPATIENT CT REQUISITION FORM

PATIENT INFORMATION

SURNAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	PROVINCE	POSTAL CODE

MOBILE PHONE #	ALTERNATE PHONE #	EMAIL

Patient consents to appointment information being disclosed to them via text or e-mail ☐ Yes, text Yes, e-mail

SEX ASSIGNED AT BIRTH	GENDER IDENTITY	DOB (YYYY/MM/DD)	HEIGHT (CM)	WEIGHT (KG)
☐ Female ☐ Male	☐ Female ☐ Male ☐ Other			

HEALTH CARD NUMBER (HN)	VERSION CODE (VC)	WSIB CLAIM #	OTHER (Self-pay, research, 3rd party payor)

☐ INTERPRETER REQUIRED Preferred language	ACCESSIBILITY CONCERNS OR REQUIREMENTS

ALTERNATE CONTACT (IF NOT PATIENT)	CONTACT NAME	CONTACT PHONE #

EXAM INFORMATION AND HISTORY

TEST/REGION(S) TO BE EXAMINED (Choosing Wisely checklists MUST accompany referrals where appropriate i.e. Spine)

- ☐ **Head**
  - ☐ Brain
  - ☐ Sinuses
  - ☐ Facial Bones
  - ☐ Temporal Bones
  - ☐ Orbits
  - ☐ Circle of Willis
- ☐ **Neck**
  - ☐ Routine
  - ☐ Carotids
- ☐ **Spine**
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
  - ☐ Sacral/Coccyx
- ☐ **Thorax**
  - ☐ Routine
  - ☐ High-resolution
  - ☐ Pulmonary Embolism
- ☐ **Thorax/Abdomen /Pelvis**
- ☐ **Abdomen/Pelvis**
  - ☐ Routine
  - ☐ Renal Colic
  - ☐ Urography
  - ☐ Enterography
- ☐ **Musculoskeletal** (please Indicate)

☐ **OTHER EXAM TYPE** (please indicate)

REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)

☐ **TIMED FOLLOW UP** **DATE REQUESTED** (YYYY/MM/DD)

CT availability is limited; requested dates will be accommodated where possible.

SCREENING & PRECAUTIONS

RENAL ASSESSMENT

☐ No known kidney issues

☐ Yes, patient has impaired renal function or a history of renal transplant

If yes, check all that apply: ☐ Has diabetes ☐ On dialysis

Please provide the most recent eGFR results (within the past 3–6 months)

eGFR RESULT (ml/min/1.73^2) **DATE COLLECTED** (YYYY/MM/DD)

- ☐ Known hypersensitivity to contrast agents
- ☐ Currently pregnant
- ☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable
- ☐ Requires general anesthesia
  Rationale

For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.

REFERRING PROVIDER

PROVIDER NAME	BILLING #	PROFESSIONAL ID

ADDRESS	CITY	PROVINCE	POSTAL CODE

PHONE #	FAX #	COPY TO

PROVIDER SIGNATURE	DATE

OFFICE USE ONLY

PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED ☐ Yes ☐ No	SPECIFIED DATE

CCO ☐ Cancer ☐ No	PROTOCOL	RADIOLOGIST