SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Imaging - FAX: 905-830-5966

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

# *Coronary CT Angiography Requisition*

| | | |
|---|---|---|
| **Patient Name:** *(print first, last)* | | **Appointment Date:** dd / mm / yy |
| **Address:** Street Number + Name Apartment | | **Appointment Time:** |
| City Province Postal Code | | **Arrival Time:** |
| **Health Card Number:** | **Version Code:** | **Hospital Record #:** |
| **Other Insurance:** | **WSIB Number:** | **Date of Birth:** dd / mm / yy |
| **Home:** ( ) | **Work/Other:** ( ) | **Patient Weight:** _____ **kg** |
| **Patient not available:** From: dd / mm / yy To: dd / mm / yy **Reason:** | | |

**CLINICAL INFORMATION:**

History of CABG ❑ Yes ❑ No If yes, specify: _____

History of coronary stent(s) insertion ❑ Yes ❑ No If yes, specify: _____

**Diagnostic question/clinical history:** _____

_____

**CONTRAINDICATIONS TO METOPROLOL**

**Heart Block** If yes, circle degree: 1 2 3 ❑ Yes ❑ No

**Left/Right ventricle failure** ❑ Yes ❑ No
Is there a Grade IV left ventricle or has there been any admission in the last 6 months for CHF?
If yes, provide the most recent LVEF= _____ %

**Pulmonary arterial hypertension** ❑ Yes ❑ No
If yes, provide RSVP= _____ mmHg

**Asthma/COPD** ❑ Yes ❑ No
Any hospital admission in the past 6 months? ❑ Yes ❑ No
Regular use of puffers? If yes, - most recent FEV1= ___ ❑Yes ❑No

**Allergy to Metoprolol** ❑ Yes ❑ No

**CONTRAINDICATIONS TO SUBLINGUAL NITROGLYCERIN**

Using Sildenafil or equivalent (Viagra/Cialis) ❑ Yes ❑ No
*If YES*, discontinue 48 hours prior to appointment date and time.*

Severe aortic stenosis ❑ Yes ❑ No

Severe anaemia ❑ Yes ❑ No

Closed angle glaucoma ❑ Yes ❑ No

Increased intracranial pressure ❑ Yes ❑ No

Recent myocardial infarction ❑ Yes ❑ No

Hypersensitivity to nitroglycerin ❑ Yes ❑ No

**CONTRAINDICATIONS TO CT CORONARY ANGIO**

Is there a history of allergy to iodinated contrast media? ❑ Yes ❑ No
If yes, provide details (e.g. hives, breathing difficulties, cardiorespiratory arrest): _____

Is there a history of renal disease? ❑ Yes ❑ No
If yes, provide the most recent serum creatinine = _____

Is there a history of chronic atrial fibrillation? ❑ Yes ❑ No

Is the patient pregnant? ❑ Yes ❑ No

Does your patient have **Diabetes mellitus:** ❑ Yes ❑ No

**Please include the following, if not available at Southlake:**

Most recent creatinine/eGFR (in the last 6 months): attach to requisition

12 lead ECG and/or rhythm strip

Any relevant consultation letter(s)

Any notes re: stents or bypass grafts

Results of any prior tests (e.g. echocardiograms, stress tests, nuclear medicine tests, angiography)

**List Current Medications**

**DIAGNOSTIC IMAGING USE ONLY** **Protocol:** ❑ Coronary CT Angiogram ❑ Pulmonary Vein **Priority Level 4, Other Diagnosis**

**Cardiologist/Radiologist Name:** *(print first, last)* **Signature:**

*** Please give your patient the **Coronary CT Angiography Patient Guide** - SL0179*

| | | |
|---|---|---|
| **Referring Physician:** *(print first, last)* | **CPSO #** | **Date:** dd / mm / yy |
| **Signature:** | | **Office Phone:** ( ) |
| **Address:** | | **Fax Number:** ( ) |

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