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: _____
Phone #: _____

CT Requisition

❑ OUT-PATIENT ❑ IN-PATIENT ❑ ED PATIENT ❑ ED CALLBACK

Patient Name: *(print first, last)*

Address: Street Number + Name Apartment

City Province Postal Code

Health Card Number: **Version Code:**

Other Insurance: **WSIB Number:**

Home: ( ) **Work/Other:** ( )

Patient not available: From: dd / mm / yy To: dd / mm / yy

Reason:

Area to be scanned:

Clinical Question:

RELEVANT CLINICAL INFORMATION: *(must be provided and please be specific)*

Appointment Date: dd / mm / yy

Appointment Time:

Arrival Time:

Hospital Record #:

Date of Birth: dd / mm / yy

Patient Weight: _____ **kg**

RENAL FUNCTION ASSESSMENT
(please check (✓) appropriate)

❑ Hx of Renal Disease ❑ Stroke
❑ On Dialysis ❑ Hypertension
❑ Diabetes ❑ Over 70 yrs of age
❑ Chemotherapy ❑ Gout
❑ Vascular Disease ❑ Cirrhosis

If **YES** to any of the above we require a current creatinine/eGFR (in the last 6 months): attached to the requisition.

❑ The patient has **NONE** of the above risk factors.

Venous Access in situ: ❑ Port ❑ PICC

Allergy to contrast ❑

Referring Physician: *(print first, last)* **CPSO #** **Date:** dd / mm / yy

Signature: **Office Phone:** ( )

Address: **Fax Number:** ( )

RADIOLOGIST USE ONLY

Head	❑ Without Contrast	❑ With Contrast
Neck	❑ Without Contrast	❑ With Contrast
Thorax	❑ Without Contrast	❑ With Contrast
Abdomen	❑ Without Contrast	❑ With Contrast
Pelvis	❑ Without Contrast	❑ With Contrast
Triphasic Liver	❑ Without Pelvis	❑ With Pelvis
Renal Mass	❑ Without Pelvis	❑ With Pelvis
Pancreas	❑ Without Pelvis	❑ With Pelvis
Facial Bones	❑ Without Mandible	❑ With Mandible
Spine	❑ C-spine	❑ L3 to S1
	❑ Other _____	
High Res Chest	❑ Inspiration ❑ Bronchiectasis ❑ Interstitial	
Thorax	❑ Aneurysm	❑ Dissection
Abdomen	❑ Aneurysm	❑ Dissection
Pelvis	❑ Aneurysm	❑ Dissection

❑ **Sinuses**	❑ **Wrist**	❑ **Pulmonary Angio**
❑ **Renal Colic**	❑ **Hip**	❑ **Carotid Angio**
❑ **Urogram**	❑ **Ankle/Foot**	❑ **Circle of Willis**

Protocol Notes:

Priority: *(please circle)*
1 2 3 4

Is this a specified date (timed) procedure?
If yes, specify date: _____

Clinical Indications for Scan:
❑ Cancer Staging and/or Diagnosis
❑ Breast Cancer Screening
❑ Other Diagnosis

Radiologist/MRT (R): *(print first, last)*

Radiologist/MRT (R) Signature:

The collecting of personal information on this form is done in accordance with Southlake's Privacy Policy. Details are available on our website, www.southlakeregional.org

SL0260_23 (4/19) "Diagnostic Imaging" Review (5/22)

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic Imaging

Patient Preparation and Information

PATIENT PREPARATION:

Please follow instructions listed below the appropriate test.

CT Abdomen and/or Pelvis:	**CT Chest:**	**CT Head or Spine or Neck:**
• Nothing to eat or drink for 2 hours prior to **appointment time**. • You may be asked to drink a clear fluid. This will help to create an outline of your digestive system. Please note that it could take up to 1 hour for the fluid to work its way through your entire digestive system.	• You may eat or drink and take medication(s) as usual. • Please bring most recent chest x-ray(s), if not done at Southlake. • You may be asked to have another chest x-ray today.	• You may eat or drink and take medication(s) as usual.

PATIENT INFORMATION:

- **Bring this requisition and your Ontario Health Card.**
- Upon arrival you are required to register for your appointment at one of our Welcome Centres or Self-Serve Kiosks before proceeding to Diagnostic Imaging Reception on East 2.
- If you are unable to keep your appointment, please call Patient Scheduling at 905-895-4521, ext. 2665.

SL0260_23 (4/19) "Diagnostic Imaging" Review (5/22)