Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING– **CT**

Tel: 613-354-3301 x263

Patient Name:
DOB:
HCN:
Address:
Phone/Cell #:

☐ Non OHIP Patient:

☐ WSIB #:

Physician Name:_____

Physician Signature:_____

OHIP Billing Physician Name/#:_____

Physician Contact #:_____

Physician Fax #:_____

Date of Referral:_____

Report Copies To:_____

****Message capable Physician phone # to confirm receipt of urgent results:**

_____

**if absent, urgent result receipt confirmation delays may occur

. INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .

PLEASE FAX COMPLETED REQUISITION TO 613-354-4331

BODY PART(S) TO BE IMAGED:_____

CLINICAL INDICATION:

Requested date/time frame:

P1 = Within 24hr ***# required*

P2 = Within 48hr ***# required*

P3 = Within 10 days = **P3c Oncology**

P4 = Routine = **P4c Oncology**

Note: DI Department triages requests based on provided history

NECESSARY Information (Circle & Fill In Blanks):

1) **IS eGFR REQUIRED FOR CONTRAST EXAM? Y* / N**
   ***YES only** if patient: 1) Age >70; 2) Has Chronic Renal Dysfunction or Solitary Kidney; 3) Hypertensive requiring medication; 4) Diabetic.

****PLEASE FAX eGFR RESULTS ALONG WITH REQUISITION**

****eGFR results must be**
< 6 months for outpatients
< 7 days for inpatients/ER
Same day for acutely ill patients

If eGFR is 30-45, please provide patient with bloodwork req for 48-72hr CRE/eGFR post CT exam.

2) **IS THE PATIENT ON HEMODIALYSIS? Y / N**
   ***If Yes,** exempt from eGFR requirements

3) **CAN THE PATIENT GIVE INFORMED CONSENT? Y / N**
   ***If NO**, written consent provision required

4) **KNOWN CONTRAST ALLERGY? YES* / NO**
   ***YES** (Circle & Specify Below) **=**

i. **Minor Reaction** (ie. Hives, Itchy)

_____

***** DI department can suggest a prophylactic medication regimen for prior Minor Reaction patients by fax. The administration of such prophylaxis is the responsibility of the referring physician.

ii. **Major Reaction** (ie. Anaphylaxis)

_____

***** Non-contrast exam only performed.

5) **PATIENT WEIGHT** _____ **lbs/kg**
CT table weight restriction: 500 lbs/225kg

Note: Oral Contrast is not required / routinely administered.

Appointment Date: (DD/MM/YY) Time: **Date Received:** **Date Notified:**