UHN Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
Michener Institute

Sinai Health

WCH WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

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TWH 399 Bathurst St. Toronto, Ont.
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600 University Av. Toronto, Ont.
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F • 416-586-3180

T • 416-323-7515
F • 416-323-6316

Medical Imaging CT Requisition Form

Requisition Completed on: _____
yyyy / mm / dd

PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL BE RETURNED

SURNAME	GIVEN NAME
BIRTHDATE: YYYY MM DD	HOSPITAL MEDICAL RECORD NO.

ADDRESS: (Street, Apt. #:)

CITY/TOWN	PROVINCE	POSTAL CODE

MOBILE PHONE NUMBER (preferred) (Area Code & Number)

(   ) _____ - _____

Health Card Number	Version Code

EXAMINATION(S)

Clinical History and Indications:

☐ **Routine**   ☐ **Emergent**   ☐ **Acute**   ☐

The following MUST be completed by the referring physician: (Please check)

1. Does the patient have a history of **Kidney disease?**   Yes ☐ No ☐
   (eg. 1 kidney, renal failure, dialysis)

2. Is the patient diabetic?   Yes ☐ No ☐

3. Previous reaction to IV contrast?   Yes ☐ No ☐

4. Does the patient have a pelvic/ileoanal pouch? Yes ☐ No ☐

If YES to question #1 or #2, please provide blood work (must be within the last 3 months)

Creatinine_____   eGFR_____

List Diabetic Medications:

Known Allergies:

IF THE PATIENT HAS A KNOWN CONTRAST ALLERGY, THE REQUESTING PHYSICIAN IS RESPONSIBLE FOR ORGANIZING THE PRE-MEDICATION PRIOR TO THE PATIENTS SCAN, PLEASE FOLLOW THE PRE-MEDICATION INSTRUCTIONS BELOW:

PREDNISONE 50mg P.O 13 HOURS AND 1 HOUR PRE-EXAMINATION PLUS BENADRYL 50mg P.O 1 HOUR PRE-EXAMINATION.

NOTE: BENADRYL CAN CAUSE DROWSINESS, PATIENTS SHOULD MAKE ARRANGEMENTS TO BE DRIVEN TO AND FROM THE EXAMINATION.

Patient Weight: _____kg/lbs.

Date of last LMP:_____
yyyy / mm / dd

Previous applicable surgery: _____   Relevant post-surgery & medical therapy _____

REFERRING PHYSICIAN INFORMATION	
Name and Initials (Print):	**Doctor's Signature:** REQUIRED
Telephone #: ( )	**Fax #: ( )**
Requested Appointment Date (if applicable):	**Billing & CPSO #** REQUIRED

Mailing Address: _____

CC report to: _____   Interpreter required if **YES** what language: _____

FORM C 13 (10/18/2021)

C13