Central Health

CT

REQUEST FOR EXAM & CONSULTATION

Date Received by MI Dept.

Medical Imaging ***INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED***

1 ***EXAM REQUIRED:*** _____

2 **PATIENT INFORMATION:**

Status: ☐ OUTPATIENT ☐ INPATIENT

☐ MCP ☐ WHSCC ☐ NR ☐ DVA ☐ DND

☐ OTHER

Name: _____

Address: _____

_____

City: _____ Postal Code: _____

DOB: _____ Sex: _____

Phone: _____ (Work): _____

MCP #: _____ Chart #: _____

3 **Please identify urgency:**

Priority	Specific Date? D/M/Y
1 Urgent (0-14 days)	
2 Non-Urgent (0-30 days)	

3 Follow-up **(DATE MUST BE SPECIFIED)**

4 **To be completed by Medical Imaging:**

Appointment date: _____

Patient Notified: ☐ Phone ☐ Message ☐ Mail

Patient preparation instructions: ☐ Yes ☐ No

Exam protocol:

IV Contrast: ☐ Yes ☐ No

Sedation: ☐ Yes ☐ No

5 **CLINICAL INFORMATION:**

Is patient on Warfarin, ASA or other anticoagulant? ☐ Yes ☐ No

Is patient receiving Metformin or Glucophage? ☐ Yes ☐ No

Has patient received IV contrast before? ☐ Yes ☐ No

Has patient had an adverse reaction to IV contrast? ☐ Yes ☐ No

Does patient have any contact precautions? ☐ Yes ☐ No

Does patient have any allergies? ☐ Yes ☐ No

Describe any allergies and reactions: _____

_____

Is patient breastfeeding? ☐ Yes ☐ No

Patient's LMP: _____

Patient's Weight: _____

Are there any risk factors for CIN? ☐ Yes ☐ No

Risk factors: Age >70 years, diabetes mellitus, renal disease, nephrotoxic drugs, organ transplant, chemotherapy, cardiovascular disease.

If risk factor present, please provide the patient's current* Creatinine level: _____ µmol/L

6 **CLINICAL INDICATIONS FOR EXAM** (including previous relevant studies): _____

_____

_____

_____

_____

CLINICAL DIAGNOSIS: _____

7 **Requesting Physician (PRINT & SIGN):** _____

Date: _____ **Phone Number:** _____

Report to be sent to Dr. (PLEASE PRINT): _____

Adapted from Eastern Health, January 2008.

FRM-DIS018