St. Michael's

Inspired Care. Inspiring Science.

CT REQUEST FORM

Tel: 416-864-6060 ex3183

Fax completed form to 416-864-3019

Patient name:

Address:

DOB: Gender: M ☐ F ☐

Health Card #: VC:

MRN

Phys Tel:	Phys Fax:	PhysBilling #:
Area to be Scanned: Clinical Information:		
Patient Height (cm)	Patient Weight (kg)	

Please answer ALL screening questions. If the following information changes before the appointment, please notify the CT department by phone or fax before the appointment day. Inaccurate information may result in cancellation on the day of exam.

	Yes	No		Yes	No
1a. Has the patient ever had a CT scan or procedure with X-ray contrast (Dye) injected?	☐	☐	4. Is there a possibility the patient may be pregnant?	☐	☐
1b. If yes, did they have an allergic reaction?	☐	☐	5a. Is the patient Diabetic? *	☐	☐
2. Does the patient have allergies to other medications? If yes, please list:	☐	☐	5b. If yes, is the patient taking Metformin (glucophage)? *		
			6. Does the patient have a history of kidney dysfunction or have a single kidney? *	☐	☐
3. Does the patient require special accommodations? (lift, ambulance, interpretation) Please list:	☐	☐	7. Is the patient over the age of 70? *	☐	☐
			Serum Creatinine: Date:		
			* If yes, eGFR and serum creatinine will be required for contrast studies.		

I attest that the contents of this form are verified and the procedure has been explained to the patient including the possibility of the use of contrast agents.

Physician's Signature: _____ Date:

Received by: Date: Time:

Protocol: Region Type

Physician's Signature: _____

Incomplete and/or illegible forms will be returned resulting in a delay of appointment booking.

Print