Providence HEALTH CARE

CT RADIOLOGY

OUTPATIENT COMPUTED TOMOGRAPHY REQUISITION

SPH: Fax to 604 806 8437

MSJ: Fax to 604-877-8132

MR MISS MRS MS	Surname	First name
Permanent address		
Postal code	Cell phone	Postal code / Cell phone
DOB	Age	Sex
Care Card Number (PHN)	☐ MSP ☐ ICBC ☐ WSBC ☐ Other	

APPOINTMENT DATE: _____ **ARRIVAL TIME:** _____

Infection precautions: ☐ None
☐ Contact
☐ Droplet
☐ Airborne
☐ Airborne & Contact
☐ Droplet & Contact

Is the patient pregnant:
☐ Yes ☐ No

Exam requested:

Allergy/Intolerance Status:
Refer to completed Caution Sheet

Previous IV contrast reaction:
☐ Yes ☐ No

Reason for scan:

Diabetes:
☐ Yes ☐ No
Must have creatinine results for diabetics

Is patient taking metformin:
☐ Yes ☐ No

Relevant history:

Renal function:
☐ Normal ☐ Abnormal
Date of collection: _____
eGFR (preferred): _____
∗OR∗
Creatinine: _____

Patient weight: _____

Relevant previous exams:
☐ **X-Ray** Date: _____
Location: _____
☐ **Ultrasound** Date: _____
Location: _____
☐ **CT Scan** Date: _____
Location: _____

Authorizing Physician: Date of request: _____ Additional copies of report to:

Printed name _____ Signature _____

College ID _____ Pager # _____