Central Intake Ontario
**Central Diagnostic Imaging Hub**
Diagnostic Imaging CT/MRI

**HOSPITAL ID:** _____

# OUTPATIENT CT REQUISITION FORM

## PATIENT INFORMATION

| SURNAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|
| | | |

| ADDRESS | CITY | PROVINCE | POSTAL CODE |
|---|---|---|---|
| | | | |

| MOBILE PHONE # | ALTERNATE PHONE # | EMAIL |
|---|---|---|
| | | |

Patient consents to appointment information being disclosed to them via text or e-mail ☐ Yes, text ☐ Yes, e-mail

| SEX ASSIGNED AT BIRTH ☐ Female ☐ Male | GENDER IDENTITY ☐ Female ☐ Male ☐ Other | DOB (YYYY/MM/DD) | HEIGHT(CM) | WEIGHT (KG) |
|---|---|---|---|---|
| | | | | |

| HEALTH CARD NUMBER (HN) | VERSION CODE (VC) | WSIB CLAIM # | OTHER (self-pay, research, 3rd party payor) |
|---|---|---|---|
| | | | |

| ☐ INTERPRETER REQUIRED<br>Preferred language | ACCESSIBILITY CONCERNS OR REQUIREMENTS |
|---|---|
| | |

| ALTERNATE CONTACT (IF NOT PATIENT) | CONTACT NAME | CONTACT PHONE # |
|---|---|---|
| | | |

## EXAM INFORMATION AND HISTORY

**TEST/REGION(S) TO BE EXAMINED**

- ☐ **Head**
  - ☐ Brain
  - ☐ Sinuses
  - ☐ Facial Bones
  - ☐ Temporal Bones
  - ☐ Orbits
  - ☐ Circle of Wilis
- ☐ **Neck**
  - ☐ Routine
  - ☐ Carotids
- ☐ **Spine**
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
  - ☐ Sacral/Coccyx
- ☐ **Thorax**
  - ☐ Routine
  - ☐ High-resolution
  - ☐ Pulmonary Embolism
- ☐ **Thorax/Abdomen /Pelvis**
- ☐ **Abdomen/Pelvis**
  - ☐ Routine
  - ☐ Renal Colic
  - ☐ Urography
  - ☐ Enterography
- ☐ **Musculoskeletal** (please indicate)

☐ **OTHER EXAM TYPE** (please indicate)

**REASON FOR EXAM /CLINICAL HISTORY** (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)

*If the patient requires emergent attention, do not submit this form to Central Intake. Please contact your nearest imaging facility directly*

☐ **TIMED FOLLOW UP** **DATE REQUESTED** (YYYY/MM/DD)

*CT availability is limited: requested dates will be accommodated where possible.*

## SCREENING & PRECAUTIONS

**RENAL ASSESSMENT**

- ☐ No known kidney issues
- ☐ Yes, patient has kidney problems, kidney transplant or is seeing a urologist

If yes, check all that apply: ☐ Has diabetes ☐ On dialysis

Please provide the most recent eGFR results (within the last 6 months)

**eGFR RESULT** (ml/min/1.73$^2$) **DATE COLLECTED** (YYYY/MM/DD)

- ☐ Known hypersensitivity to contrast agents
- ☐ Currently pregnant
- ☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable
- ☐ Requires general anesthesia
  Rationale

*For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.*

## PREFERRED LOCATION

| All patients will be triaged to the shortest distance unless a preferred location is entered. | PREFERRED LOCATION(S) |
|---|---|
| | |

**OTHER ROUTING CONSIDERATIONS**

## REFERRING PROVIDER

| PROVIDER NAME | | BILLING # | | PROFESSIONAL ID |
|---|---|---|---|---|
| | | | | |

| ADDRESS | CITY | PROVINCE. | POSTAL CODE |
|---|---|---|---|
| | | | |

| PHONE # | FAX # | COPY TO |
|---|---|---|
| | | |

| PROVIDER SIGNATURE | DATE |
|---|---|
| | |

## OFFICE USE ONLY

| PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4 | TIMED ☐ Yes ☐ No | SPECIFIED DATE |
|---|---|---|
| | | |

| OH ☐ Cancer ☐ No | PROTOCOL | RADIOLOGIST |
|---|---|---|
| | | |