Bluewater Health

Department of Diagnostic Imaging

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Computerized Tomography Consultation

☐ **CODE STROKE - CT HEAD (for ER / INPT only)**
☐ **24hr follow-up from tPA Start Time:**_____

☐ **ED** ☐ Out Pt ☐ In Pt

Patient Name_____

Address_____

_____ Postal Code_____

Phone: Home _____ Alternate _____

D.O.B._____ (DD/MM/YYYY) Sex ☐M ☐F

Health Card No. _____VC_____

Incomplete Requests Will Be Returned resulting in a delay of this procedure
***Sections MUST be completed**

***RELEVENT CLINICAL HISTORY / DIFFERENTIAL DIAGNOSIS / CLINICAL QUESTION TO BE ANSWERED (PLEASE PRINT)**

REASON FOR SCAN: ☐ Cancer Staging/Dx ☐ Diagnosis (other) ☐ Follow-up ☐ Surgical Planning

TYPES OF SCAN - AREAS OF CONCERN**ATTACH REPORTS FOR REVELANT PREVIOUS DIAGNOSTIC EXAMS*

ALL EXAMS - NOTHING SOLID BY MOUTH 3 HOURS PRIOR TO EXAM. (Except for Spines/Extremities/Renal Colic - NO RESTRICTIONS)

HEAD
☐ Routine
☐ Orbit
☐ Sinus/Face
☐ Other Area:_____

NECK
☐ Routine

CHEST
☐ Routine
☐ Nodule f/up
☐ Pulmonary Angio
☐ Aortic Angio
☐ Other Area:_____

ABDOMEN/PELVIS
☐ Abdomen /Pelvis
☐ Renal Colic
☐ CT Angio_____
☐ Other Area:_____

MUSCULOSKELETAL
☐ Bony Pelvis - No Prep
☐ Extremities
☐ Cervical Spine (Levels)
☐ Thoracic Spine (Levels)
☐ Lumbar Spine (Levels)
☐ Other Area:_____

***PATIENTS PERSONAL HEALTH HISTORY * MUST BE COMPLETED**

	YES	NO		YES	NO
Contrast Allergy			Previous Chemotherapy		
Acute Hypotension			Renal Disease or Solitary Kidney		
Collagen Vascular Disease			Sepsis		
Dehydration or volume contraction			Vascular Disease / Nephrotoxic Drugs		
Diabetes Mellitus			Power PICC		
HIV / AIDS			Portacath		
Organ Transplant			Age 70 or older?		

If any of the above risk factors apply, a serum creatinine level And estimated GFR is required within 6 months of the exam, assuming the pateint is medically stable. If intravenous contrast is required for the exam, a booking will not be given until this is provided.

_____ Date of Lab Work (DD/MM/YYYY)

_____ Creatinine Level umol/L (Adult M 57-113 F 39-88)

_____ estimated GFR uml/min/1.73m (>90)

RADIOLOGIST USE ONLY

RADIOLOGIST: RD YA VK AC AS IA

CT PROTOCOL

IV:
☐ C -
☐ C +
☐ Oral
☐ RP

PRIORITY LEVEL
☐ 1— Emergent
☐ 2— Inpatient/Urgent
☐ 3— Cancer Staging/Dx
☐ 4— Non-urgent

SPECIFIED DATE PROCEDURE
☐ 2 SDP
☐ 3 SDP
☐ 4 SDP

☐ RAD Check

PATIENT APPOINTMENT:

DATE: _____

TIME: _____

G#_____

***Physician Name (Print):**	***Date**
***Signature:**	Report Copies: