CHATHAM-KENT
Health Alliance

Department of Diagnostic Imaging
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REQUEST FOR CT CONSULTATION

Medical Registration #: _____
Name: _____
Surname: Middle First
Date of Birth: _____ (yyyy mm dd)
Address: _____
City: _____ Prov.: _____
Postal Code: _____
Telephone #: _____
Health Card #: _____
WSIB #: _____

Physician Name: _____
Address: _____
Postal Code: _____ Phone: _____
Referring Hospital: _____
Inpatient ☐ Outpatient ☐ ED Patient ☐ Clinic ☐
Floor _____ Wheelchair ☐ Stretcher ☐
Copy reports to: _____

Date Received _____ (yyyy mm dd) Time
Date Booked _____ (yyyy mm dd)

CT RESTRICTIONS:
Maximum allowable weight 400lbs/181 kg

Examination Requested: _____

Clinical History (must be entered). _____

YES	NO	**THE FOLLOWING MUST BE COMPLETED BEFORE THE CT WILL BE BOOKED**
		Is the patient allergic to radiographic IV contrast?
		Does the patient have or is there a family history of Malignant Hyperthermia?
		Is there a history of multiple myeloma, heart disease, sickle cell anemia or other? List:

IF YES TO ANY OF THE FOLLOWING QUESTIONS BELOW, A RECENT CREATININE (<3 MONTHS) & A CREATININE CLEARANCE MUST BE CALCULATED BEFORE THE CT WILL BE BOOKED.

		Is there a history of renal impairment or nephrectomy?
		Is the patient currently on dialysis?
		Is the patient over 70 years old?
		Is the patient diabetic?
		If yes, do they take medication called Metformin, Glucophage or Avandament?
		Does the patient have other medical conditions or take any medications that may predispose to nephrotoxicity? Please list: _____

Patients weight: _____ kg
Urea: _____ mmol/L (Normal = 2.4-8.0 mmol/L)
Serum Creatinine: _____
Creatinine Clearance (CrCl): _____ mL/min
(Normal Range > 90 mL/min)

$$\text{CrCl (mL/min)} = \frac{(140 - \text{Age}) \times \text{weight (Kg)} \times \textit{constant}^*}{\text{Serum Creatinine (mmol/L)}}$$

**constant is 1.23 for men or 1.04 for women*

☐ Patient given prescription for Mucomyst if required ☐ Oral (Non-Emergency ☐ IV (Urgent-4hr) ☐ IV (Emergency-30 min)
☐ CT Oral Contrast Prescription *(physician approval required to administer oral contrast for inpatients)*

PREVIOUS RELATED EXAMS
Exam Type: _____
Where: _____
Date: _____ (yyyy mm dd)

_____
Ordering Physician's Signature (required)

****RADIOLOGIST'S USE ONLY**** PRIORITY 1 2 3 4 T OT SD BC
☐ >60 Isovue ☐ 30-60 Mucomyst & Isovue ☐ <30 NonContrast
****INCOMPLETE REQUESTS WILL BE RETURNED-RESULTING IN DELAY/CANCELLATION OF THE PROCEDURE****