CT

Computed Tomography (CT) Requisition

Providence HEALTH CARE

☐ ST. PAUL'S HOSPITAL
1081 Burrard St., Vancouver, BC V6Z 1Y6
Phone: 604-806-8071 Fax: 604-806-8437

☐ MOUNT SAINT JOSEPH HOSPITAL
3080 Prince Edward Street,
Vancouver, BC V5T 3N4
Phone: 604-877-8323 Fax: 604-877-8132

MR MISS MRS MS SURNAME	FIRST NAME		
PERMANENT ADDRESS			
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE
DATE OF BIRTH (MONTH / DAY / YEAR)	AGE	SEX	
HEALTH CARE #	MSP ☐	WCB ☐	ICBC ☐ OTHER ☐

TO SCHEDULE AN APPOINTMENT PLEASE FAX OR MAIL COMPLETED REQUISITION TO CT DEPARTMENT

Infection Concerns?
☐ YES ☐ NO
SPECIFY: _____

Is the Patient Pregnant?
☐ YES ☐ NO

Previous IV Contrast Reaction?
☐ YES ☐ NO

Diabetes Mellitus?
☐ YES ☐ NO
MUST HAVE CREATININE RESULTS FOR DIABETICS

Is Patient Taking Metformin?
☐ YES ☐ NO

Renal Function?
☐ NORMAL ☐ ABNORMAL
eGFR (preferred): _____
or
CREATININE: _____

Allergies?
☐ YES ☐ NO
SPECIFY: _____

Patient's Weight?
_____

Relevant Previous Exams?
☐ X-Ray ☐ CT ☐ U/S
DATE: _____
LOCATION: _____

Exam Requested

Relevant History – Reason for Scan

DATE | SIGNATURE OF AUTHORIZING PHYSICIAN

Please Print NAME

_____ Prac. No. _____

ADDITIONAL COPY OF REPORT TO: _____

Department Use Only

☐ With ☐ Without ☐ Oral

PRIORITY: ☐ **1** ☐ **2** ☐ **3**

☐ Head ☐ Chest ☐ Abdomen ☐ Pelvis

Appointment Date: _____ Arrival Time: _____ CT Time: _____