

Bluewater Health

Department of Diagnostic Imaging

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Sarnia, ON N7T 6S3
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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. _____ Sex M F
(DD/MM/YYYY)

Health Card No. _____ VC _____

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

***RELEVANT 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 RELEVANT 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: _____

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: _____

NECK

- Routine

***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 patient 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 _____ Creatinine Level umol/L _____ (Adult M 57-113 F 39-88) estimated GFR uml/min/1.73m (>90)
(DD/MM/YYYY)

RADIOLOGIST USE ONLY

PATIENT APPOINTMENT:

RADIOLOGIST: RD YA VK AC AS IA

DATE: _____

CT PROTOCOL **IV:** **PRIORITY LEVEL** **SPECIFIED DATE PROCEDURE**
 C - 1— Emergent 2 SDP
 C + 2— Inpatient/Urgent 3 SDP
 Oral 3— Cancer Staging/Dx 4 SDP
 RP 4— Non-urgent

TIME: _____

G# _____

RAD Check

*Physician Name (Print): _____

*Date _____

*Signature: _____

Report Copies: _____



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