

## **All Sites and Facilities**

Last Name:			
First Name (Preferre	ed Name):		
Encounter number:	NH Nu	mber:	Chart Created: Y/N
Date of Birth:	Gender:	Age:	Encounter Type:
Responsibility for Payment:		PHN:	
Primary Care Physic	cian/Attending	Physician:	
DATIENT I AREI			

Computed Tomography R	equisition	Page 1 of 2	Primary Care P		ng Physician:	
Department Use Only. Requisition Received Date: Time:			pointment: te:		Time:	
Important: "*" fields must be completed to	avoid delays in pat				11110.	
Patient Information	avoid delayo iii pat	ioni processii	9			
Last Name*:	First Name*:				Personal Health	n Number*:
Address*:	City *: Province:	Pos	tal Code:		Date of Birth*:	YYYY-MM-DD
Primary Phone*: Alternate Phone*:	Height (cm)*: Gender:	Weight (kg	)*:	Interpreter Specify La	Required: No	Yes
Bill To: ☐ MSP Insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other: ICBC/WSBC Number:					:	
Mobility Requirements: Ambulance	☐ Wheelchair ☐ M	/lechanical Lift	nical Lift Walk Stretcher Bed		☐ Bed ☐ Ba	riatric
Isolation precations:	_ Infection Concer	ns: VRE	Active TB	MRSA 🗌	C.diff  Other:_	
Outpatient Inpatient ER	ICU Other:					
Ordering clinician timeframe request: guidelines to determine the priority for schedul	ing the patient.)	- '			·	-
P1: within 24 hours P2: 2 to 7 days	s P3: 8 to 30 day	ys P4: 31	to 60 days	P5: specifi	c date/follow up:	
Exam requested*:			Ordering clinician's name (print)*:MSP #*:			
Previous relevant exams:		Signatu	ıre:			
		Copies				
Previous centre:  Clinical findings/history/clinical question (		Phone	#"		Urgent	report requested
Previous history of contrast reaction?	Yes □ No Does pa	atient have kid	ney problems	or a kidney	transplant? 🗌 Ye	es 🗌 No
Specify:					cialist or urologis	t? 🗌 Yes 🗌 No
	Is the pa	atient on metfo	ormin? 🗌 Ye	s 🗌 No		
Provide a current creatinine/eGFR: Outpa within 7 days.				inpatients		☐ Yes ☐ No ☐ Yes ☐ No
	nine:		dwork date:_	1		
Radiologist protocol:	P3 □ P4 □ P5	Initials:			INJ Sticker	
Pre-scan instructions (explain):						
Contrast: ☐ IV ☐ Oral ☐ Non cont☐ With and without contrast	rast	☐ Arterial / time:	☐ Portal			
Booking clerk: Booked with:				1 hour wait	4 hour fast	gastrografin
Technologist comments:						
Pregnant? ☐ Yes ☐ No LMP (Y'	YYY-MM-DD):	P	V site:	b	y:	
Shielding used: Yes No IV Conti	rast: Yes No	If yes:		mL at	mL/sec	

Tech initial:

DLP:

Injection time:



## **All Sites and Facilities**

## **Computed Tomography Requisition**

First Name (Preferre	ed Name):			
Encounter number:	NH Number:		Chart Created: Y/N	
Date of Birth:	Gender:	Age:	Encounter Type:	
Responsibility for Pa	ayment:	PHN:		
Primary Care Physic				

Computed Tomography Nequisition	Page 2 of 2	PATIENT LABEL
Medical Imaging Prioritization and Communication		
To be completed by Medical Imaging personnel:		
☐ Radiologist required		
Notes for booking stant:		
To be completed by booking personnel:		
Attempts to book:		
1		Place flashcard label here
2		TUNG! NO!C
3		
Notes:		
Appointment date: Time:		