northern health
*the northern way of caring*

Facility
Facility Address
Facility Phone and Fax
Facility Day of Operations and Hours

Last Name:
First Name (Preferred Name):
Encounter number: NH Number: Chart Created: Y/N
Date of Birth: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:

*PATIENT LABEL*

# Computed Tomography Requisition



| **Department Use Only**<br>Requisition Received Date: Time: | Appointment Date: Time: |
|---|---|

**Important:** "*" fields must be completed to avoid delays in patient processing.

## Patient Information

| Last Name*: | First Name*: | Personal Health Number*: |
|---|---|---|
| Address*: | City *:<br>Province: Postal Code: | Date of Birth*:<br>YYYY \| MM \| DD |
| Primary Phone*:<br>Alternate Phone*: | Height (cm)*: Weight (kg)*:<br>Gender: | Interpreter Required: ☐ No ☐ Yes,<br>specify language: |

☐ _____(Name of delegate)_____ can book this appointment for the patient

**Mobility Requirements:** ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift ☐ Walk ☐ Stretcher ☐ Bed ☐ Bariatric

**Bill To:** ☐ MSP Insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other: _____ ICBC/WSBC Number:

**Infection Concerns:** ☐ VRE ☐ Active TB ☐ MRSA ☐ C.diff ☐ Other: _____ ☐ Isolation precautions:

☐ Outpatient ☐ Inpatient ☐ ER ☐ ICU ☐ Other:

Ordering clinician timeframe request – Note: Medical Imaging department will review with the relevant clinical information provided using Provincial BCMOH guidelines to determine the priority for scheduling the patient.
☐ P1: within 24 hours ☐ P2: 2 to 7 days ☐ P3: 8 to 30 days ☐ P4: 31 to 60 days ☐ P5 specific date/follow up _____

MI reviewed Priority P _____ Initials _____

| **Exam requested*:** _____<br>_____<br>_____<br>Previous relevant exams: _____<br>Previous centre: _____ | Ordering clinician's name (print)*: _____<br>MSP #*: _____<br>Signature: _____<br>Copies to*: _____<br>Phone #*: _____ ☐ Urgent report requested |
|---|---|

Clinical findings/history/clinical question (must be legible)*:

| Previous history of contrast reaction? ☐ Yes ☐ No<br>Specify: | Is the patient diabetic? ☐ Yes ☐ No<br>Is the patient on **metformin**? ☐ Yes ☐ No<br>- If yes, must discontinue **metformin** 48 hours post contrast. |
|---|---|

**All patients requiring contrast must have serum creatinine and eGFR testing prior to scanning Renal Function**
Patients less than 19 years of age with no prior history of renal impairment or chronic underlying medical conditions do not need bloodwork prior to scan.
Patients with no history of renal dysfunction must have a serum creatinine and eGFR within 3 months prior to scan.
Patients with a history of renal dysfunction must have a serum creatinine and eGFR within 48 hours of scan.
eGFR: _____ Creatinine: _____ Bloodwork date: _____

Power PICC: ☐ Yes ☐ No
Power VAD: ☐ Yes ☐ No

**Radiologist protocol:**
Pre-scan instructions (explain):

**Contrast:** ☐ IV ☐ Oral ☐ Non contrast ☐ With and without contrast ☐ Pre ☐ Arterial ☐ Portal ☐ Delay time: _____

INJ Sticker

**Booking clerk:** Booked with: _____ ☐ 1 hour wait ☐ 4 hour fast
☐ **gastrografin** Appointment date: _____ Appointment time: _____

**Technologist comments:**
Pregnant? ☐ Yes ☐ No LMP (YYYY-MM-DD): _____ IV site: _____ by: _____
Shielding used: ☐ Yes ☐ No IV Contrast: ☐ Yes ☐ No If yes: _____ mL at _____ mL/sec
Injection time: _____ Tech initial: _____ DLP: _____

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*PATIENT LABEL*

# Computed Tomography Requisition



MEDICAL IMAGING PRIORITIZATION AND COMMUNICATION

To be completed by Medical Imaging personnel:

☐ Radiologist required
Notes for booking staff:

To be completed by booking personnel:

Attempts to book:
1.

2.

3.

Notes:

*Place flashcard label here*