DIAGNOSTIC IMAGING – CT SCAN

Huntsville District Memorial Hospital (HDMH)
100 Frank Miller Drive
Huntsville, ON, P1H 1H7
T: 705-789-2311 x2242
F: 705-788-1485

South Muskoka Memorial Hospital (SMMH)
75 Ann Street
Bracebridge, ON, P1L 2E4
T: 705-645-4404 x3112
F: 705-645-7567

PATIENT BOOKING LINE: 1-877-348-6264

Patient Demographics:

Name Last First

Address

Home Phone ( ) - Other Phone ( ) -

☐ **Do not contact patient.** Provide appointment date/time to referring provider.

DOB YYYY / MM / DD ☐ Male ☐ Female

OHIP

Isolation Precautions: ☐ Contact ☐ Droplet/Contact ☐ Airborne

Special Instructions (mobility, communication, etc): _____ ☐ Stretcher ☐ Wheelchair ☐ Ambulance

Exam Request:

☐ Outpatient
☐ Emerg Patient
☐ Inpatient *(if req'd, bloodwork <7 days)*

Future date requested: _____

Relevant Clinical History: (please include enough detail for Radiologist to assign Cancer Care Ontario priority level)

WSIB Claim #_____

Note: *Patients wearing clothing without zippers, buttons or embellishments may not have to change for CT exams.*

Please note: Spines and/or extremities may not have contrast and therefore blood work may not be required

Risk Factors for Contrast Nephropathy

☐ Kidney Surgery/Transplant/Ablation
☐ Chronic Kidney Disease (CKD)
☐ Prior Acute Kidney Injury (AKI)
☐ Albuminuria
☐ **NO RISK FACTORS**

Is the patient on dialysis? Yes ☐ No ☐

Allergies: ☐ Yes ☐ No

Allergy to: _____

☐ Previous IV contrast reaction

When & what type: _____

Additional items of importance:

☐ Asthma ☐ Breast Feeding ☐ Pregnancy

☐ Will the patient require sedation?
(To be provided/administered by referring physician)

If any CIN risk factors are present, provide the following:

☐ Blood work pending

Creatinine (within 6 months): _____

Date of Lab Results: _____

Weight: _____ kg **eGFR:** _____
(Max table weight 200kg)

HDMH: Ordering physician **MUST** call radiologist on call after 2100hrs Monday-Friday, on holidays/weekends for urgent CTs.
SMMH: Ordering physician **MUST** call radiologist on call after 2100hrs Monday-Friday, on holidays/weekends for urgent CTs.

☐ Discussed with Radiologist Radiologist Protocol code: _____ Approving Radiologist: _____

Referring Provider:	Signature:	
Copies to:	Date:	OHIP Billing #:

Radiologist/ Office use only

Appointment Date: _____ Time: _____ Requisition Rec'd: _____

CCO Priority Level coding: *VERSION: October 2022*

☐ Priority 1 (Emergent <24 hrs)
☐ Priority 2 (Inpatient or Urgent <48hrs)
☐ Priority 3 (Semi-Urgent <10 DAYS)
☐ Priority 4 (Non-Urgent <28days)

☐ T2 (Time Specific <48hrs)
☐ T3 (Time Specific<10 Days)
☐ T4 (Time Specific ROUTINE)

☐ Breast Cancer Screening
☐ Cancer Staging and/or Diagnosis
☐ Other