# Cardiac CT Angiography (CCTA) Requisition

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RMH Use Only

| Patient's Name: | Most Recent Weight: | Appointment Date: | Estimated Scan Time: |
|---|---|---|---|
| Date of Birth *(mm/dd/yy)*: | Health Card #: | **Arrival Time:** | |
| Mailing Address: | Patient Contact Number: | **Duration of Appt:** **2 - 3 hours** | |

Referring Physician: *(print and sign)*

**Patient Prep:**
- NPO with exception of water and regular medications 4 hours prior to hospital arrival
- No caffeine 12 hours prior to exam (no coffee, cola drinks, tea, energy drinks)
- No Viagara, Levitra or Cialis 24 hours before scan

## Clinical Information (attach copies of notes):

History of CABG ☐ No ☐ Yes – details ____________________

History of coronary stent(s) insertion ☐ No ☐ Yes – details ____________________

Symptoms/Other history: ____________________

**List Medications:**

***Radiologist Use Only:***
Priority Level 1 2 3 4

**Radiologist:**

**No booking will be given unless ALL information is completed**

### Contraindications to Cardiac CT Angiography

Is there a history of allergy to iodinated contrast media? **Yes** ☐ **No** ☐
If 'yes, provide details (e.g. hives, breathing difficulties, cardiorespiratory arrest):
____________________

Is there a history of renal disease? **Yes** ☐ **No** ☐

**Provide most recent serum creatinine** ____________________

Is there a history of chronic atrial fibrillation? **Yes** ☐ **No** ☐

Is the patient pregnant? **Yes** ☐ **No** ☐

Any hospital admission in the past 6 months? **Yes** ☐ **No** ☐

**Fax results of prior tests (echocardiograms, stress tests, nuclear medicine tests, and angiography)**

### Contraindications for Metoprolol (Lopressor)

Does the patient have any of the following?

**Heart Block** **Yes** ☐ **No** ☐
if 'yes,' circle degree 1 2 3

**Left/Right ventricle failure** **Yes** ☐ **No** ☐

Is there a Grade IV left ventricle or has there been any admission in the last 6 months for CHF? **Yes** ☐ **No** ☐
If 'yes,' provide the most recent LVEF = _______%

**Pulmonary arterial hypertension** **Yes** ☐ **No** ☐
If 'yes,' provide RVSP = ___________mmHg

**Asthma/COPD**
Regular use of Puffers? **Yes** ☐ **No** ☐
If 'yes,' provide most recent FEV1 = ________

### Contraindications to Sublingual Nitroglycerin

Is there a history of:

| | | |
|---|---|---|
| Using Sildenafil (Viagra/Cialis or equivalent) | **Yes** ☐ | **No** ☐ |
| Aortic stenosis | **Yes** ☐ | **No** ☐ |
| Severe anemia | **Yes** ☐ | **No** ☐ |
| Closed angle glaucoma | **Yes** ☐ | **No** ☐ |
| Increased intracranial pressure | **Yes** ☐ | **No** ☐ |
| Recent myocardial infarction | **Yes** ☐ | **No** ☐ |
| Hypersensitivity to Nitroglycerin | **Yes** ☐ | **No** ☐ |