ROSS MEMORIAL HOSPITAL
Kawartha Lakes

C.T. Scan Requisition

10 Angeline St. N., Lindsay, ON, K9V 4M8
Tel: 705-328-6196 Fax: 705-328-6197

Physician Data (print or imprint below)

OP or **IP** or **Emerg** - **Rm #**: _____ & **Ext #** _____

Name: _____

Address: _____

City: _____ Phone: _____

Date of Birth: _____

OHIP: _____

MRN #: _____

Referring Doctor: _____

Family Doctor: _____

Other Specialists: _____

FAX #: _____

WSIB: Yes ☐ No ☐

Claim # _____

ISOLATION PRECAUTIONS – MUST BE COMPLETED

☐ Not Required ☐ Airborne ☐ Droplet ☐ Contact

CT to be done by: _____/20_____

Patient weight: _____

height: _____

Area(s) to be scanned:

Clinical Info / Differential Diagnosis:

Physician's Signature: _____Date: _____

Adverse reaction to X-ray dye? Yes ☐ No ☐
Is Pt Diabetic? Yes ☐ No ☐
Possibility of Pregnancy? Yes ☐ No ☐

Renal Disease

CKD Yes ☐ No ☐
Prior AKI Yes ☐ No ☐
Is patient on Dialysis Yes ☐ No ☐
Kidney surgery or ablation Yes ☐ No ☐
Albuminuria Yes ☐ No ☐

State Creatinine level / date: _____

The above must be completed and signed by the physician.

This area is for Radiology use only

Priority 1 2 3 4 T

☐ Cancer (staging/diagnostic)
☐ High Risk Breast Cancer
☐ Other

Appointment Date

Req received date: _____ Time: _____ Initials: _____