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 #** __________

MRN #: ______________________________

Name: ____

Referring Doctor: ______________________

Address: ____

Family Doctor: ________________________

City: ______________________________ Phone: ______________

Other Specialists: ______________________

Date of Birth: ____

FAX #: _________________________________

OHIP: ________________________

ISOLATION PRECAUTIONS – MUST BE COMPLETED

☐ Not Required ☐ Airborne ☐ Droplet ☐ Contact

WSIB: Yes ☐ No ☐

Claim # ______________________________

Patient weight: ________________

height: ________________

CT to be done by: ________________________/20_______

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

Req received date: ____________________________ Time: _____________ Initials: _____________

Appt created date: ____________________________ Time: _____________ Initials: _____________

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