RMH Use Only

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

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

Name: _____
Address: _____
City: _____ Phone: _____
Date of Birth: _____
OHIP: _____

WSIB: Yes ☐ No ☐
Claim # _____

ISOLATION PRECAUTIONS – MUST BE COMPLETED

☐ Not Required ☐ Airborne ☐ Droplet ☐ Contact

CT to be done by: _____/20_____

MRN: _____
Referring Doctor: _____
Family Doctor: _____
Other Specialists: _____
FAX #: _____

Patient - weight: _____
- height _____

Adverse reaction to X-ray dye? Yes ☐ No ☐
Is patient on dialysis? Yes ☐ No ☐
Is Pt Diabetic? Yes ☐ No ☐

State Creatinine level/date: _____

Req verified by: _____

Area(s) to be scanned:

Clinical Info / Differential Diagnosis:

Physician Data (print or imprint below)

Appointment Date:

Physician's Signature: _____Date:_____

☐ DART Form attached

The above must be completed and signed by the physician.

This area is for Radiology use only

Priority 1 2 3 4 T

Clinical Indication for Scan:

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

PPE worn:

☐ Gloves
☐ Gown
☐ Mask
☐ N95 Mask
☐ Eye Shield

IV Contrast	_____mL	**Omni**	**Visi**
Omnipaque	_____mL	Oral	Rect
Glucagon	_____mL	IV	
Hyoscine	_____mL		
PegLyte	_____mL		
EsophaCat	_____g	Oral	

Creatinine Clearance_____

Requisition Rec'd - Date: _____ Time: _____ Initials: _____

Appointment Created - Date: _____ Time: _____ Initials: _____