

Request for CT Consultation

(Computed Tomography)

HNHB LHIN

Last Name		First Name	
HIN/HCN/OHCN/OHIP #		Date of Birth (yyyy/mm/dd)	
Address			
City / Province		Postal Code	
Phone Number:		Mobile Number:	
Gender	Weight (kg)	Age	

REQUEST TO: _____ Referral Date: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Brantford General Hospital
Phone: 519-751-5545
Fax: 519-752-9983 | <input type="checkbox"/> Greater Niagara General
Phone: 905-378-4647
Fax: 905-358-7438 | <input type="checkbox"/> Haldimand War Memorial Hospital (Dunnville)
Phone: 905-774-7431
Ext: 1221
Fax: 905-774-7914 |
| <input type="checkbox"/> Hamilton General Hospital
Phone: 905-521-2100
Ext: 49600
Fax: 905-527-9053 | <input type="checkbox"/> Joseph Brant Hospital
Phone: 905-336-4126
Fax: 905-336-4148 | |
| <input type="checkbox"/> Juravinski Hospital & Cancer Centre (Hamilton)
Phone: 905-389-4411
Ext: 41484
Fax: 905-387-8813 | <input type="checkbox"/> McMaster University Medical Centre & Children's Hospital (Hamilton)
Phone: 905-521-2100
Ext: 41484
Fax: 905-521-5086 | <input type="checkbox"/> Norfolk General Hospital
Phone: 519-426-0130
Ext: 2219
Fax: 519-429-6892 |
| | <input type="checkbox"/> St. Catharines Hospital
Phone: 905-378-4647
Fax: 905-684-6990 | <input type="checkbox"/> St. Joseph's Healthcare (Hamilton)
Phone: 905-522-1155
Ext: 35278
Fax: 905-521-6166 |
| | | <input type="checkbox"/> Welland Hospital
Phone: 905-378-4647
Fax: 905-732-9537 |

Referring Physician: _____ Unit: _____ Phone: _____
Printed Name Signature & Designation

Hospital/Other Facility: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Send Additional Report to: Primary Care Physician Other: _____
Printed Name Phone Number Fax

Exam Payee:
 OHIP WSIB # Self Third Party
Specify: _____

Patient Routing:
 Hospital preference: _____
 Next available appointment at any hospital

Exam Requested (be specific): _____
Current Patient Location: Inpatient Outpatient Emergency
Language Preferred: English French Other: _____
Interpreter Required? Yes No

Clinical Information / Relevant History: _____
Please answer all of the following questions:
1) Known Renal Disease? YES / NO
2) Known Diabetes? YES / NO
3) On Metformin? YES / NO
If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:
eGFR: _____ ml/min/1.73² Date (yyyy/mm/dd): _____
Creatinine: _____ ml/min/1.73 Date (yyyy/mm/dd): _____
4) Known Contrast Allergy?
If yes, has the patient been provided with the pre-medication instructions listed below:
 Prednisone 50 mg PO 12 hours and 2 hours pre-procedure
 Diphenhydramine 50 mg PO/IV 1 hour pre-procedure

Relevant tests to date:

Study (e.g. CT/MRI/Xray)	Date (yyyy/mm/dd)	Location

If this is a follow-up exam, please indicate requested date:
_____ (yyyy/mm/dd)

FOR CT USE ONLY

Reviewed by: _____ Date: _____
Printed Name Signature & Designation (yyyy/mm/dd)

Priority: 1 2 T2 3 T3 4 T4 Test Date: _____ Test Time: _____
(yyyy/mm/dd) (hh:mm)

Clinical Indication: Cancer Other: _____

Protocol: _____ Radiologist (printed): _____
Date Protocolled: (yyyy/mm/dd)

Additional Comments: _____ Signature: _____