NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA

Clear This Form

☐ **Next available appointment at any NHS CT Site**

PLEASE FAX TO LOCATION NEAREST PATIENT'S RESIDENCE

Or Choose:

☐ GNG	905-378-4647	Fax 905-358-7438
☐ SCG	905-378-4647	Fax 905-684-6990
☐ WHS	905-378-4647	Fax 905-732-9537

CT Consultation Requisition

Temporary McMaster-NHS CT Head Rule Study SCS Only

Please PRINT patient information below. Please do not imprint.

INCOMPLETE REQUISITIONS WILL BE RETURNED

MANDATORY

Surname	First Name		Allergy History
D.O.B.	Sex	H.C.N.	
Referring Physician	Physicians to receive copies of report		

Canadian CT Head Rule Has to be completed for ***all non contrast Head CT***

1. CCTHR Exclusion Criteria

- ☐ Not a trauma
- ☐ GCS <13
- ☐ Age <16
- ☐ Anticoagulants or Bleeding D/O
- ☐ Open Skull #

2. Any Exclusions Met?

YES → Proceed to exclusion

NO

- ☐ GCS <15 2hrs post injury
- ☐ Suspected Open or Depressed Skull #
- ☐ Any sign of Basal Skull #
- ☐ Age 65yr or older
- ☐ Vomiting 2 or more times
- ☐ Amnesia 30min before impact
- ☐ Dangerous Mechanism (Pedestrian vs car, MVA with ejection, Fall 3ft or more)

3. Was CCTHR Met?

- ☐ **Excluded** from Rule
- ☐ **YES** (CT head recommend)
- ☐ **NO** (CT head not recommend)

Important Note: *This req is part of a NHS & McMaster NRC Study. The CT head will be performed if ordered regardless of the CT Head Rule. Clinical judgment is paramount.*

Head	Chest	Abdomen / Pelvis	Retroperitoneum	Other
☐ Routine *Must Complete CCTH Rule above if ordered*	☐ Routine	☐ Liver	☐ Adrenals	☐ Extremity (specify area)
☐ Sinus	☐ High Resolution	☐ Pancreas	☐ Kidneys	☐ Spine (specify area)
☐ Orbits	☐ Pulmonary Embolus	☐ Spleen	☐	☐ Bony Pelvis
☐	☐	☐ Aorta	☐	☐ Neck
☐	☐	☐ Renal Colic	☐	☐

NOTE THE SECTIONS ON HISTORY AND FINDINGS AND RENAL HISTORY BELOW, INCLUDING A PHYSICIAN'S SIGNATURE, MUST BE COMPLETED BEFORE AN APPOINTMENT WILL BE PROVIDED.
RELEVANT PREVIOUS IMAGING STUDIES MUST ACCOMPANY THE PATIENT AT THE TIME OF THE CT APPOINTMENT

History and Findings – include previous imaging and laboratory studies

Physician's Signature:_____

ER Doc's Name & Direct Extension are Mandatory --> _____

Renal History

Does your patient have any history of renal impairment or dialysis treatment? ☐ Yes ☐ No

Does your patient have any history of hypertension, or vascular disease? ☐ Yes ☐ No

Does your patient have diabetes? ☐ Yes ☐ No

If yes are they on Metformin? ☐ Yes ☐ No

Does your patient have any family history of renal disease? ☐ Yes ☐ No

Your patient may require contrast media during this study, if the answer is "Yes" to any of the above, or your patient is older than 70 yrs., please provide a creatinine level performed within the last 2 months.

Creatinine_____ µmol/L or GFR _____

WTIS Clinical Indication for Scan

- ☐ Cancer Staging / Diagnosis
- ☐ Other

Radiologist Protocol

1 2 3 4 D E (office use only)

Date Requisition Received

D M Y INIT

Date Notified

D M Y INIT

Appointment: Day [ ] Month [ ] Year [ ] Time: _____HRS WHS ☐ GNG ☐ SCG ☐