

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	<input type="checkbox"/> Not a trauma	2. Any Exclusions Met?	NO	Proceed to exclusion >>>>	3. Was CCTHR Met?	<input type="checkbox"/> Excluded from Rule
	<input type="checkbox"/> GCS <13			<input type="checkbox"/> GCS <15 2hrs post injury		<input type="checkbox"/> YES (CT head recommend)
	<input type="checkbox"/> Age <16			<input type="checkbox"/> Suspected Open or Depressed Skull #		<input type="checkbox"/> NO (CT head not recommend)
	<input type="checkbox"/> Anticoagulants or Bleeding D/O			<input type="checkbox"/> Any sign of Basal Skull #		
	<input type="checkbox"/> Open Skull #			<input type="checkbox"/> Age 65yr or older		
				<input type="checkbox"/> Vomiting 2 or more times		
				<input type="checkbox"/> Amnesia 30min before impact		
				<input type="checkbox"/> Dangerous Mechanism (Pedestrian vs car, MVA with ejection, Fall 3ft or more)		

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
<input type="checkbox"/> Routine <i>Must Complete CCTH Rule above if ordered</i>	<input type="checkbox"/> Routine	<input type="checkbox"/> Liver	<input type="checkbox"/> Adrenals	<input type="checkbox"/> Extremity (specify area)
<input type="checkbox"/> Sinus	<input type="checkbox"/> High Resolution	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Kidneys	<input type="checkbox"/> Spine (specify area)
<input type="checkbox"/> Orbits	<input type="checkbox"/> Pulmonary Embolus	<input type="checkbox"/> Spleen	<input type="checkbox"/>	<input type="checkbox"/> Bony Pelvis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Aorta	<input type="checkbox"/>	<input type="checkbox"/> Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Renal Colic	<input type="checkbox"/>	<input type="checkbox"/>

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

Renal History

Physician's Signature: _____

Urgent Result Contact Number: _____

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	Radiologist Protocol	Date Requisition Received	
<input type="checkbox"/> Cancer Staging / Diagnosis <input type="checkbox"/> Other	1 2 3 4 D E (office use only)	D M Y	INIT
		Date Notified	
		D M Y	INIT

Appointment: Day [] Month [] Year [] Time: _____ HRS WHS GNG SCG