Peterborough Regional Health Centre
Diagnostic Imaging Services
C.T. REQUISITION
Outpatient Booking: Fax 705-876-5046
Inpatient Booking : Fax 705-876-5127

☐ Inpatient ☐ Outpatient ☐ Wheelchair ☐ Ambulatory ☐ Non Ambulatory Hospital: Transportation: ☐ Ambulance ☐ Car Physician Data: Name: Phone: Billing #:	Patient Data (Print or place imprint upper right corner) Last Name: First Name: Sex: ☐ Male ☐ Female Address: City: Postal Code: Phone: DOB (dd/mm/yyyy) Health Card #:

Report to: Dr: ; Dr: ;Dr:
Area(s) to be scanned:

History/Clinical Information (relevant to exam requested):

Previous related Imaging: ☐ No ☐ Yes If yes, where:
WSIB: ☐ No ☐ Yes If yes, Claim #:

➔ INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED ←

Risks for Contrast Induced Nephropathy:
Blood work is **required** and must be **included** with CT request for patients with **ANY** of the following:

☐ Known Renal Dysfunction If Yes, explain:
☐ Dialysis
☐ Diabetes Mellitus
☐ Age (over 70 yrs.)
☐ Multiple Myeloma
☐ Oncology Patient
☐ On Metformin/metformin containing drug
☐ Solitary Kidney
☐ PATIENT DOES **NOT** HAVE ANY ABOVE RISK FACTORS

CREATININE _____ (u mol/L) *eGFR _____ (ml/min) PATIENT WEIGHT: ____
Date Drawn: (dd/mm/yyyy)
(Outpatients required bloodwork within 60 days of exam date)

Previous Adverse Reaction to Contrast (x-ray dye)? ☐ No ☐ Yes
If yes, explain
Possibility of Pregnancy: ☐ No ☐ Yes
Is patient able to give informed consent? ☐ No ☐ Yes If no, please have POA accompany patient.

Ordering Physician signature: Date:

Radiologist Coding Area: Priority: ☐ 1 ☐ 2 ☐ 3 ☐ 4 (Staging/Dx)_____(Breast) _____ (Other) _____	Received: Booked: Notified: