FAX Req to:

☐ HHHS 705- 457 – 1071

Persons with any of the following conditions are considered to have **"a Renal Insufficiency"** and will need a Creatinine for their CT Scan (if contrast required) Please check the boxes:

Y / N

- ☐ ☐ Previous Kidney Surgery, Transplant, Ablation
- ☐ ☐ Referral from a Nephrologist or Urologist
- ☐ ☐ CKI – (Chronic Kidney Injury)
- ☐ ☐ Prior AKI – (Acute Kidney Injury)
- ☐ ☐ Albuminuria

C.T. Scan Requisition

For after hours emergencies (till 2000hrs) – call Rad on-call sitting at PRHC at 705-743-2121 ext 3382

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_____

Exam #:_____

Referring Doctor: _____

Family Doctor: _____

Other Specialists: _____

FAX #: _____

Patient weight: _____ Patient height: _____

Is patient pregnant? (11-55 yo females) Yes ¨ No ¨

Adverse reaction to X-ray dye? Yes ¨ No ¨

Is patient on dialysis? Yes ¨ No ¨

Is patient 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)

Sending HHHS Physician: _____
Phone # 705-457-3721

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

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

PPE worn:

¨ Gloves
¨ Gown
¨ Mask
¨ N95 Mask
¨ Eye Shield

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

Creatinine Clearance_____