

Waterloo Wellington Hospitals CT Requisition

OFFICE USE ONLY

Exam Date: _____

Arrival Time: _____

Exam Time: _____

Fax completed requisition to ONE Hospital:

- | | | | |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> Cambridge Memorial Hospital: (CMH) | 519-740-4990 | <input type="checkbox"/> Guelph General Hospital: (GGH) | 519-766-9982 |
| <input type="checkbox"/> Grand River Hospital: (GRH) | 519-749-4296 | <input type="checkbox"/> St. Mary's General Hospital: (SMGH) | 519-749-6513 |
| <input type="checkbox"/> Groves Memorial Community Hospital:(GMCH) | 519-787-4405 | | |

Patient Information		Other Reqs Associated to Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	
Last Name, First Name: _____		Health Card #: _____	VC: _____
DOB: DD/MM/YYYY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		WSIB? <input type="checkbox"/> Y <input type="checkbox"/> N	Injury Date: DD/MM/YYYY
Street Address: _____		Please include Claim #: _____	
City/Town: _____		Other Insurance? Third Party or Self Pay	
Province: _____ Postal Code: _____		Specify: _____	
Contact Number: _____		Required Patient Information:	
Home: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		Height: _____ (cm)	Weight: _____ (kg)
Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		<input type="checkbox"/> Restricted Mobility	<input type="checkbox"/> Outpatient
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		<input type="checkbox"/> Pediatric Under 10 yrs	<input type="checkbox"/> In-Patient Rm/Loc
<input type="checkbox"/> Y <input type="checkbox"/> N An interpreter is required to consent to the procedure. CMH, GGH, GRH and SMGH have interpretation services available.			

EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUISITIONS WILL BE RETURNED**			
Ordering Physician Name (Please print): _____		Urgency	
Contact #: _____ Fax#: _____		Signature _____	<input type="checkbox"/> Urgent
		Date _____	<input type="checkbox"/> Semi-Urgent
			<input type="checkbox"/> Routine

Copy to (Please print)																																			
Region/Organ of Interest: Clinical History/Indication (reason for exam): Previous Relevant Imaging and Surgery (please specify):	<table border="1" style="width:100%"> <tr> <th colspan="2" style="text-align:center">Patient Safety Screening (physician to complete with patient)</th> </tr> <tr> <td>Allergy to x-ray dye/contrast</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">If yes, please describe type of reaction: _____</td> </tr> <tr> <td>Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N LMP (specify) DD/MM/YYYY</td> <td></td> </tr> <tr> <td>Breastfeeding</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">Renal Assessment**:</td> </tr> <tr> <td>Kidney problems/disease</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Prior Kidney Surgery</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Dialysis</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>High Blood Pressure/ Cardiovascular disease/Stroke/TIA</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Diabetes Mellitus</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>If yes, is patient on Metformin/Glucophage</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Past/Current treatment with NSAIDs, Diuretics, Chemotherapy or other Nephrotoxic drugs</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Greater than 60 yrs of age</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">**If you answered yes to any of the above, a creatinine and eGFR within the last 3 months must be provided</td> </tr> <tr> <td>Creatinine: _____</td> <td>Date: _____</td> </tr> <tr> <td>eGFR: _____</td> <td>Date: _____</td> </tr> </table>	Patient Safety Screening (physician to complete with patient)		Allergy to x-ray dye/contrast	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please describe type of reaction: _____		Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N LMP (specify) DD/MM/YYYY		Breastfeeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Renal Assessment**:		Kidney problems/disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Prior Kidney Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure/ Cardiovascular disease/Stroke/TIA	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes Mellitus	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, is patient on Metformin/Glucophage	<input type="checkbox"/> Y <input type="checkbox"/> N	Past/Current treatment with NSAIDs, Diuretics, Chemotherapy or other Nephrotoxic drugs	<input type="checkbox"/> Y <input type="checkbox"/> N	Greater than 60 yrs of age	<input type="checkbox"/> Y <input type="checkbox"/> N	**If you answered yes to any of the above, a creatinine and eGFR within the last 3 months must be provided		Creatinine: _____	Date: _____	eGFR: _____	Date: _____
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Protocol: Initial: Rad _____ Tech _____	WTIS Priority <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 T: _____	WTIS Reason <input type="checkbox"/> Staging/Diagnosis Ca <input type="checkbox"/> Other Requisition Received Date and Time: _____ DD / MM / YYYY _____ HR / MM

Please indicate location of Imaging examination for Patient:

Cambridge Memorial Hospital 700 Coronation Blvd. Cambridge ON N1R 3G2	Telephone: 519-621-2333 x2244 Fax: 519-740-4990 www.cmh.org	<ul style="list-style-type: none">• CT Service is located in the hospital's Diagnostic Imaging Department the 1st Floor of the hospital's A Wing. All patients are asked to register in the department at their arrival time.
Grand River Hospital 835 King St. W Kitchener ON N2G 1G3	Telephone: 519-749-4262 Fax: 519-749-4296 www.grhosp.on.ca	<ul style="list-style-type: none">• CT Service is located in the hospital's Department of Medical Imaging on the 2nd Floor of the hospital's D Wing. All patients are asked to register in the department at their arrival time.
Groves Memorial Community Hospital 131 Frederick Campbell Street Fergus ON N1M 0H3	Telephone: 519-843-2010 Fax: 519-787-4405 www.gmch.ca	<ul style="list-style-type: none">• All patients are to register in the hospital's Central Registration, located on the Ground Floor, at the indicated arrival time.
Guelph General Hospital 115 Delhi St. Guelph ON N1E 4J4	Telephone: 519-837-6413 Fax: 519-766-9982 www.gghorg.ca	<ul style="list-style-type: none">• CT Service is located in the hospital's Diagnostic Imaging Department on the 3rd Floor of the hospital. All patients are asked to register in the department at their arrival time.
St. Mary's General Hospital 911 Queen's Blvd Kitchener ON N2M 1B2	Telephone: 519-749-6455 Fax: 519-749-6513 www.smgh.ca	<ul style="list-style-type: none">• CT Service is located in the hospital's Diagnostic Imaging Department on the 1st Floor. All patients are asked to register in the department at their arrival time.

Exam Preparation

Cambridge Memorial Hospital	<p>Abdomen/Pelvis: Pick up E-Z-Cat in Diagnostic Imaging Department at least 1 day prior to exam date. Nothing to eat 4 hours prior to exam time. Start drinking E-Z-Cat 1 hour prior to exam time. Drink completely ½ hour before exam time.</p> <p>Small Bowel Enterography and Colonography: Pick up instructions from your physician or from the Diagnostic Imaging Department at the hospital at least 3 days prior to the exam date</p> <p>All other exams: Nothing to eat 4 hours prior to exam.</p>
Grand River Hospital	<p>All Exams: No solid foods 4 hours prior to exam time.</p> <p>Pediatric patients with sedation: Nothing to eat or drink 4 hours prior to exam time</p> <p>Pediatric patients without sedation: Nothing to eat or drink 2 hours prior to exam time</p> <p>Colonography: Instruction sheets will be mailed to patient</p>
Groves Memorial Community Hospital and Guelph General Hospital	<p>All exams: Nothing to eat 3 hours prior to exam. Drink 2 x 12oz glasses of water prior to exam. You may void as needed as a full bladder is not required for this exam.</p> <p>Abdomen/Pelvis: Pick up Readicat in Diagnostic Imaging Department at least 1 day prior to exam date. Nothing to eat 3 hours prior to exam time. Start drinking Readicat 2 hours prior to exam time. Drink slowly to finish ½ hour before exam time.</p> <p>Small Bowel Enterography: Exam will last up to 1.5 hours. Clear fluids only for 24 hours. Take 1 bottle of Citromag (296 ml) at 4:00 pm the day before the examination. Citromag can be purchased at the pharmacy.</p> <p>Colonography: Pick up prep and instructions from the Diagnostic Imaging Department at the hospital at least 3 days prior to the exam date</p>
St. Mary's Hospital	<p>All Exams: No solid foods 4 hours prior to exam time.</p>

Important

- Please bring your **Ontario Health Card** and this form to your appointment
- **Patients must be able to consent to the procedure. If language is a barrier, please bring an interpreter.**
- You will be asked to remove any metal, jewelry, piercings that are in the area of the body part being imaged
- If you are unable to keep your appointment, please give us 24 hours' notice
- We kindly ask that you do not wear or apply fragrances in support of our Fragrance Free policies.