RVH
Royal Victoria Regional Health Centre

Appointment

Date: _____

Time: _____

Request for CT Scan Consultation

Royal Victoria Regional Health Centre
Imaging Services
Tel. (705) 739-5610
Fax. (705) 739-5649

Name: _____ Gender: □ M □ F

Address: _____

City: _____ Postal Code: _____

Health Card #: _____

Date of Birth *(DD/MM/YYYY)*: _____

Home #: _____

Cell #: _____

Please allow 1 week to receive notification of appointment.

To be completed by referring physician:
Area to be examined (be specific):

Diagnostic Question/Clinical History:

Are you requesting a timed follow-up procedure (e.g., 6 month follow-up)? If yes, date requested (DD/MM/YYY):

To be completed by the referring physician with the patient:

Risk Factor for Contrast-Induced Acute Kidney Injury (CI-AKI):

History of kidney disease (chronic kidney disease, remote acute kidney injury, kidney surgery, ablation) □ **Yes** □ **No**

If YES to the above, a current creatinine (within 3 months of appointment) is required.

Serum Creatinine: _____ Date obtained: _____

Patient Weight: _____kg

Is the patient currently on dialysis? □ **Yes** □ **No**

If yes and patient has residual urine output (at least one cup/day), has the patient been cleared for contrast by a nephrologist? □ **Yes** □ **No**

Is the patient allergic to CT contrast media? □ **Yes** □ **No**

If yes, please describe reaction type and estimate severity:

_____

Is the patient pregnant? □ **Yes** □ **No**

Mobility:
□ Walk □ Wheelchair □ Stretcher □ MEDICAL LIFT

For Radiologist Use ONLY:

□ **P1** □ **P2** □ **P3** □ **P4** ***Rad/MRT:*** _____

□ Ca Stage/Dx □ Ca Surveillance □ Breast Ca Screen □ Other

CHEST/ABDO/PELVIS	A	B	C
CHEST	A	B	C
ABDOMEN	A	B	C
PELVIS	A	B	C
NECK	A	B	C
HEAD	A	B	C
COMP HEAD	A	B	C
SPINE	A	B	C
EXTREMITY	A	B	C

□ CTA (be specific):_____
□ Colonography
□ Cardiac □ Cardiac Mass □ Calcium Score Only

OTHER:

To be completed by the referring physician:
Referring Physician (please print): _____
Address: _____City: _____ Postal Code: _____
Tel #: _____ Fax #: _____

Physician Signature:

Date:

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Information for CT Examinations

Please read carefully.

Your doctor has requested a CT (Computed Tomography) examination for you, during which x-rays are used to produce information for computers to reconstruct cross-sectional images of various parts of the body.

When you arrive at the hospital, please check in at Imaging Services reception on the 2nd floor near the Main Entrance.

Please follow the instructions relevant to your examination:

CT Scan Head, Chest, Neck, Spine or Extremities
NO preparation.

OR

CT Scan Abdomen and/or Pelvis (with Contrast)

1) Drink one litre of water over the one hour prior to your appointment time. You can urinate as needed.

2) DO NOT eat or drink for 2 hours prior to your appointment, **with the exception of one litre of water required for the prep (refer to number 1).**

Please be aware you could be in the department for approximately 2-3 hours. About 15 minutes of that time will be spent in the scan room.

Emergency patients take precedence and may cause delays, however, we try to keep on schedule.

If you have allergies, kidney problems, or if there is a chance that you might be pregnant, please tell the technologist or nurse when you arrive.

**If you have to cancel your appointment, please notify us immediately.
Please note: due to the high volume of procedures requested, re-booking an appointment may result in several weeks delay before an appointment is available.
Please call (705) 739-5610.**

For environmental reasons, Imaging Services has stopped issuing plastic bags for patients to store their garments during their exam. We ask that patients bring their own reusable bag.

R.ICT