



Appointment

Date: _____

Time: _____

Request for CT Scan Consultation

Royal Victoria Regional Health Centre

Medical Imaging

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/YYYY):

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**

Is the patient allergic to CT contrast media? **Yes** **No**
If yes, please describe reaction type and estimate severity:

(Please provide patient with premedication if required)

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

Ambulation:

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 Medical Imaging reception on the 2nd floor.

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

- 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, Medical Imaging has stopped issuing plastic bags for patients to store their garments during their exam. We ask that patients bring their own reusable bag.

