Mackenzie Health

**Mackenzie Richmond Hill Hospital**
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

**Cortellucci Vaughan Hospital**
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

**www.mackenziehealth.ca/ct**

# CT Requisition

**Tel:** 905-883-2004 **Fax: 905-883-2096**

☐ **Other Insurance / WSIB #** _____

**MRN:** _____

Referring Physician: _____
Billing#: _____
Referring Physician Signature: _____
Additional Reports to: _____
Referring Physician Address: _____
Referring Physician Office Phone: _____
Referring Physician Fax: _____

**Patient Name:** *(Print Last, First)*

**Address:**

**Health Card Number:** **Version Number:** **Date of Birth:** (dd/mm/yyyy)

**Primary Number: ( )** ☐ **Cell** ☐ **Home** ☐ **Work ( )**

**Secondary Phone Number: ( )** ☐ **Cell** ☐ **Home** ☐ **Work ( )**

**Clinical History and Diagnostic Questions:** ☐ **Cancer screening, diagnosis or staging?**

**Specific exam date request?** _____ (dd/mm/yyyy)

**EXAM REQUIRED (check all that apply)**

| **Routine Protocols** | | | **Musculoskeletal Protocols** | | |
|---|---|---|---|---|---|
| Head | ☐ Without Contrast | ☐ With Contrast | Shoulder | ☐ Right | ☐ Left |
| Neck | ☐ Without Contrast | ☐ With Contrast | Elbow | ☐ Right | ☐ Left |
| Thorax | ☐ Without Contrast | ☐ With Contrast | Wrist | ☐ Right | ☐ Left |
| Abdomen | ☐ Without Contrast | ☐ With Contrast | Hand | ☐ Right | ☐ Left |
| Pelvis | ☐ Without Contrast | ☐ With Contrast | Pelvis | ☐ Bony | |
| **Specialized Head Protocols** | | | Sl joints | ☐ Bilateral | |
| Orbits | ☐ Without Contrast | ☐ With Contrast | Hip | ☐ Right | ☐ Left |
| Sinus | ☐ Routine | ☐ Landmark (ENT) | Knee | ☐ Right | ☐ Left |
| Facial bones | ☐ Without Mandible | ☐ With Mandible | Ankle | ☐ Right | ☐ Left |
| Temporal Bone (Middle Ear) and Mastoids | ☐ Without Contrast | ☐ With Contrast | Foot | ☐ Right | ☐ Left |
| IACs (Acoustic) | ☐ Without Contrast | ☐ With Contrast | Other | ☐ Specify: | |
| **Specialized Body Protocols** | | | | | |
| High Res Chest | ☐ Interstitial | ☐ Bronchiectasis | **Angiography Protocols** | | |
| Coronary Arteries | ☐ Angiogram | ☐ Calcium Scoring | Carotid/Vertebral/Circle of Wills | ☐ Single Phase | |
| Liver (Triphasic) | ☐ Routine with pelvis | ☐ Without pelvis | Circle of Willis only | ☐ | |
| Pancreas | ☐ Routine with pelvis | ☐ Without pelvis | Pulmonary Angiogram | ☐ | |
| Adrenals | ☐ | | Renal/Mesenteric Angiogram | ☐ | |
| Kidney (Renal Mass) | ☐ With delayed bladder | ☐ Without delayed bladder | Runoff | ☐ | |
| Urogram | ☐ | | Aortogram (aneurysm) | ☐ Thoracic only ☐ Entire Aorta ☐ Abdominal only | |
| Renal Colic | ☐ Without Contrast (kidneys to Bladder) | | | | |
| **Spine Protocols (Without Contrast)** | | | Aortogram (dissections) | ☐ Thoracic only ☐ Entire Aorta ☐ Abdominal only | |
| Cervical | ☐ Specify levels: | ☐ C1 to T1 | Other Specify**:** ☐ | | |
| Thoracic | ☐ Specify levels | | **Other Request** | | |
| Lumbar | ☐ Specify levels ☐ L3-S1 | ☐ Navigation Planning | ☐ Specify: | | |
| Other | ☐ Specify levels: | | | | |

## RENAL RISK FACTORS

If **YES** to any of the below, we require a current creatinine and eGFR (in the last 6 months) attached to the requisition.

The patient has **NONE** of the below risk factors ☐

☐ Hx to Renal Disease ☐ Diabetes ☐ Vascular Disease ☐ Hypertension ☐ Cirrhosis
☐ On Dialysis ☐ Chemotherapy ☐ Stroke ☐ Over 70 yrs of age ☐ Gout

Date of Bloodwork: _____ (dd/mm/yyyy) Creatinine _____umol/L eGFR _____ ☐ Allergy to contrast

Does the patient speak fluent English? If not, are they able to bring an interpreter who can speak fluent English? ☐ No ☐ Yes

**The MRP should hold Metformin for 48 hours AFTER IV contrast to minimize any renal damage.**

**Pre-Medication will be required for patients with previous allergic reactions to contrast.**

3003

(Rev. Nov 16, 2023)