



Mackenzie Richmond Hill Hospital
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Richmond Hill, Ontario
L4C 4Z3

www.mackenziehealth.ca/ct

CT Requisition

Tel: 905-883-2004 / 905-832-4554 Ext. 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: # _____ **Street:** _____ **Apt:** _____ **City/Town:** _____ **Province:** _____ **Postal Code:** _____

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

Primary Number: () Cell Home Work ()

Secondary Phone Number: () Cell Home Work ()

Clinical History and Diagnostic Question: Cancer diagnosis or staging?

Specific exam date requested? _____

EXAM REQUIRED (check all that apply)

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