Oakville Trafalgar Memorial Hospital
3001 Hospital Gate, Oakville ON L6M 0L8
Booking Office:
Telephone: 905-338-4604
Fax: 905-845-9921

Name: _____ M / F

Address: _____

_____

Phone: (H) _____ (W)_____

D.O.B. _____ Health Card #: _____

Unit # : _____

Diagnostic Imaging Department

CARDIAC CT Scan Requisition

Office Use Only	**Diagnostic Imaging Protocol Use Only**
Appointment Date: _____ _____ / _____ / _____ **Day DD MM YYYY**	**Contrast Media: ❒ No ❒ Yes**

IMPORTANT NOTICE

1. A booking will NOT be made for any CT examination unless ALL sections of this form are completed by the Referring Physician
2. If the test is requested based on abnormalities found on imaging outside Halton Healthcare, the relevant images/films/reports **MUST** accompany the requisition
3. The requisition **must be completed and signed by the physician**
4. Requisitions are to be faxed to Oakville: 905-845-9921

Patient Weight: _____ (table limit 484 lbs / 220 kg)

REASON(S) FOR REFERRAL (please check all that apply)	**PRE BETA-BLOCKER SCREENING (please complete for all patients)**
❑ Aortic Root / Aortic Valve / Thoracic Aorta ❑ Diagnosis of Coronary Artery Disease (CAD) ❑ Equivocal other non-invasive testing ❑ Initial test to evaluate CAD ❑ Follow-up of pre-existing CAD ❑ Evaluation of Bypass Graft Patency ❑ Other	Resting HR: _____ BP:_____ **Yes** **No** ❑ ❑ Beta-blocker intolerant asthma ❑ ❑ Allergy to beta-blockers ❑ ❑ 2nd or 3rd degree heart block ❑ ❑ PATIENT CLEARED FOR BETA-BLOCKER ❑ ❑ Viagra currently prescribed
Clinical Information:	Allergies to medications? ❑ No ❑ Yes - please state:
Previous Studies (Please attach reports):	_____
	Allergy to IV Contrast Media containing Iodine? ❒ No ❒ Yes
	Is the patient diabetic? ❒ No ❒ Yes - if "Yes", any prescription for Metformin must be discontinued for 48 hours after the examination. The patient will be given an information sheet after the examination.
	Where possible please complete the following:
Echo:	BUN: _____ Creatinine: _____
CT/MRI:	Does patient require the services of an interpreter? ❒ No ❒ Yes
	Is patient subject to claustrophobia? ❒ No ❒ Yes
Referring Physician (please print): _____ Physician Phone #: _____ Fax #: _____	Report copies to: Physician (please print): _____ Fax#: _____

Physician's Signature Date

Incomplete And / Or Unsigned Requisitions Will Be Returned

Date Stamp:

H3898