



# Diagnostic Imaging Department

## CT REQUISITION

NAME: \_\_\_\_\_ M / F

ADDRESS: \_\_\_\_\_

DO WE HAVE CONSENT TO LEAVE INFORMATION PERTAINING TO YOUR APPOINTMENT?  YES PHONE #: \_\_\_\_\_

D.O.B \_\_\_\_\_ HEALTH CARD # \_\_\_\_\_

UNIT #: \_\_\_\_\_

### APPOINTMENT

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

### APPOINTMENT LOCATION

- Georgetown 1 Princess Anne Dr, ON L7G 2B8 Ph:905-873-4596 Fax: 905-873-4593
- Milton 725 Bronte St. S ,ON L9T 9K1 Ph:905-876-7023 Fax:905-876-7003
- Oakville 3001 Hospital Gate, ON L6M 0L8 Ph:905-338-4604 Fax:905-845-9921

### CT EXAM REQUESTED – Please be specific / specify levels

- Head  Sinus  Neck
- Chest  Abdomen  Pelvis
- Renal Colic  Kidneys Only
- Spine (MRI recommended) (specify levels) \_\_\_\_\_
- CT Angio (specify vessels of interest) \_\_\_\_\_
- MSK/Soft Tissue (specify region of interest) \_\_\_\_\_
- Other \_\_\_\_\_

MRI generally recommended for w/u of solid organ lesions

### CLINICAL INFORMATION:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### RELEVANT PREVIOUS STUDIES

- Halton Healthcare  External \_\_\_\_\_

Requisition must include external reports or booking will be delayed.

For follow-up of, or for comparison to previous outside studies, the patient must bring the outside IMAGES to the appointment or a delay in interpretation may result while we attempt to obtain.

Referring Physician: \_\_\_\_\_

Copy Report to: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

It is not necessary to complete the Risks for Contrast Nephropathy portion (below), for the following studies:

- CT Head (Unless metastatic work-up)
- CT Sinuses
- CT Chest: Screening / Follow-up / HRCT
- CT Renal Colic
- CT Spine Or Extremities
- CT Study to be completed without Contrast Injection  Yes

### RISKS FOR CONTRAST NEPHROPATHY / ALLERGIC RXN (must be completed for all IV contrast studies)

	Yes	No
Dehydration	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Renal Impairment (Surgery, transplant, solitary kidney, insufficiency)	<input type="checkbox"/>	<input type="checkbox"/>

If "YES" for any of the above risk factors, you MUST provide the following:

eGFR \_\_\_\_\_ Unstable

Date of Blood Test: \_\_\_\_\_

**\*\*Must be within 4 weeks**

	Yes	No
Acute Kidney Injury (AKI)	<input type="checkbox"/>	<input type="checkbox"/>

### ALLERGIES

	Yes	No
Allergy to CT or Angiographic contrast media	<input type="checkbox"/>	<input type="checkbox"/>

If yes, complete specifics on back of requisition and fax with requisition

### DIALYSIS

	Yes	No
Patient on dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Producing urine	<input type="checkbox"/>	<input type="checkbox"/>

### REQUIREMENTS

	Yes
Interpreter	<input type="checkbox"/>
Sign Language	<input type="checkbox"/>
Hoyer Lift	<input type="checkbox"/>
Special Needs	<input type="checkbox"/>
Please indicate needs _____	

PLEASE NOTE TABLE WEIGHT LIMIT IS 220 KG

\*h3611-a\*

NAME-----

### Guidelines for Screening and Prevention of Contrast Induced Nephropathy

**For Patients with One or More Risk Factors:** Please provide eGFR from within 1 month for outpatients and within 48 hours for acutely ill or inpatients. In emergent situations, eGFR may be waived

For further information about contrast media (including contrast induced nephropathy and allergic reactions) please refer to: <https://www.acr.org/Clinical-Resources/Contrast-Manual>

**METFORMIN PROTOCOL**

IF eGFR is < 30, Metformin must be discontinued for 48 hours post CT contrast injection. It should only be reintroduced after renal function has been confirmed as stable at 48 hours post injection.

**HYDRATION PROTOCOL**

Hydration Protocol	IV normal saline 300 ml x 1 hours pre CT and normal saline 350 ml / hr 2 hrs post CT or 2-3 L of oral hydration prior to CT exam
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**CONTRAST MEDIA ALLERGY PRE-MEDICATION**

SYMPTOMS		ELECTIVE PREMEDICATION PROTOCOL
<b>I. MILD</b> (self-limited without progression)	<input type="checkbox"/> Limited urticarial/pruritus <input type="checkbox"/> Limited cutaneous edema <input type="checkbox"/> Limited "itchy"/"scratchy" Throat <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Sneezing/conjunctivitis/rhinorrhea	NOT FORMALLY REQUIRED – but, as per patient preference diphenhydramine can be prescribed which may prevent prior mild reaction. Please note if used patient will require a driver.
<b>II. MODERATE</b> (more pronounced and commonly require medical management)	<input type="checkbox"/> Diffuse urticarial/pruritus <input type="checkbox"/> Diffuse erythema, stable vital signs <input type="checkbox"/> Facial edema without Dyspnea <input type="checkbox"/> Throat tightness or hoarseness without dyspnea <input type="checkbox"/> Wheezing/bronchospasm, mild or no hypoxia	50 mg Prednisone by mouth at 13 hours, 7 hours and 1 hour before contrast administration, AND  50 mg Diphenhydramine intravenously, intramuscularly, or by mouth 1 hour before medium administration
<b>III. SEVERE</b> (Often life-threatening)	<input type="checkbox"/> Diffuse edema, or facial edema with dyspnea <input type="checkbox"/> Diffuse erythema with Hypotension <input type="checkbox"/> Laryngeal edema with stridor and/or hypoxia <input type="checkbox"/> Anaphylactic shock (hypotension and tachycardia)	Other Modality or non-enhanced CT is recommended. If CT with contrast is required then Radiologist consult is necessary and above pre-medication will be required.
OTHER: _____		

Accelerated IV Premedication (**for ER or INPATIENTS** where timely imaging precludes the above favoured oral protocol)  
 Methylprednisolone sodium succinate (e.g. Solu-Medrol\*) 40 mg IV or hydrocortisone sodium succinate (e.g. Solu-Cortef\*) 200 mg IV immediately, and then every 4 hours until contrast medium administration, plus diphenhydramine 50 mg IV 1 hour before contrast medium administration. This regimen usually is 4-5 hours in duration.