Ontario
South West Local Health Integration Network

Choosing Wisely Canada™

CT REQUISITION – this form can be found on www.swpca.ca Check one Site:

☐ Alexandra Marine and General Hospital-Goderich	F: 519-524-8532	☐ Middlesex Hospital Alliance - Strathroy	F: 519-246-5930
☐ Grey Bruce Health Services - Owen Sound	F: 519-376-3952	☐ South Bruce Grey Health Centre -Walkerton	F: 519-881-1388
☐ Hanover and District Hospital	F: 519-364-0062	☐ St. Joseph's Health Care London	F: 519-646-6204
☐ Huron Perth Health Care Alliance - Stratford	F: 519-272-8247	☐ St. Thomas Elgin General Hospital	F: 519-631-8842
☐ Listowel Memorial Hospital	F: 519-291-2813	☐ Tillsonburg District Memorial Hospital	F: 519-842-4299
☐ LHSC – UH	F: 519-663-3034	☐ Woodstock Hospital	F: 519-421-4238
☐ LHSC – VH /Children's	F: 519-667-6826		

PATIENT INFORMATION:

Surname: _____ First Name: _____ Middle Initial: _____

Gender: ☐ M ☐ F ☐ X Date of Birth (YYYY-MM-DD): _____

Street Address: _____ Apt: _____ City: _____ Province: _____ Postal Code: _____

Health Card No. : _____ Version Code: _____ Research or 3rd Party No.: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ ED

WSIB: ☐ Y ☐ N _____ WSIB No.: _____ Date of Injury (YYYY-MM-DD): _____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ☐ EN ☐ OTHER _____

Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric ☐ Interpreter Required

Y N Please check the following:

☐ ☐ Allergic to radiographic contrast
☐ ☐ Pregnant ____ wks.
☐ ☐ Heparin Flush Ordered
☐ ☐ Power PICC
☐ ☐ CT Porta Cath
☐ ☐ History of Cancer

Precautions

☐ TB ☐ MRSA
☐ VRE ☐ Shingles

***If yes to any of the risk factors please draw creatinine levels*

Y N Contrast Risk Factors:

☐ ☐ Diabetic
☐ ☐ On dialysis
☐ ☐ History of impaired renal function or Nephrectomy
☐ ☐ Patient > 70 yrs old
☐ ☐ On any diabetic medications: _____
☐ ☐ Hypertension
☐ ☐ Medications/conditions predisposing to nephrotoxicity
☐ ☐ Other:_____

☐ Y ☐ N Related surgery
☐ Y ☐ N Urgent
☐ Y ☐ N Routine
☐ Y ☐ N Timed _____
☐ Y ☐ N Cancer
☐ Y ☐ N Staging/ Followup
_____ Timing of above

Please attach previous imaging and reports (ie ECG)

REFERRING PHYSICIAN:

Name _____ Address: _____

City: _____ Postal Code: _____ Tel: _____ FAX: _____

Physician's Signature: _____ Billing No: _____

Copy to: _____ Date: _____

Serum Creatinine (must be drawn within the past 6 months)

Result: _____

eGFR: _____

Sample date:_____

Height: cm/in. _____

Weight: kg/lbs. _____

EXAMINATION REQUESTED:

WORKING DIAGNOSIS:

CLINICAL INFORMATION:

FOR BOOKING STAFF

Prep Information

☐ No prep required
☐ Clear fluids only 4 hours prior
☐ Drink 1 bottle of water en route & do not void
☐ Patient may be here 2+ hours
☐ Bring list of medications
☐ Start IV # _____
☐ Consent obtained by MRP

Appointment Date:

Arrival Time:

OFFICE USE ONLY

Protocol:

☐ Water Prep ☐ Barium ☐ Water Soluble ☐ Enterography Prep
☐ IV ☐ Rectal ☐ Non Contrast ☐ without and check
☐ Nitro ☐ Beta Blockers ☐ Hyoscine (Buscopan)
☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed: _____
Staff Initials: _____

FOR TECHS/RADS

NOTE: This requisition may be booked at an alternate site in the South West LHIN to improve patient access.

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CT SPINE APPROPRIATENESS CHECKLIST

Choosing Wisely Canada

Patient label placed here, or minimum information below required

This checklist is based on the **Choosing Wisely** *criteria and the* **CORE Back Tool**. *It is required for all adult (18+) outpatient CT spine referrals.* ***Please include with CT requisition. For most clinical concerns, CT should be ordered only if there is an MRI contraindication as MRI is superior to CT. Exceptions include suspected fracture, further characterization of known bone lesion, pre-surgical or post-surgical assessment.***

Patient Name: _____
Date (YYYY-MM-DD): _____
Date of Birth (YYYY-MM-DD): _____
Gender: ☐ M ☐ F ☐ X
Health Card #: _____

Referring Physician Name: _____

A. Red Flags requiring Emergent Management (immediate CT and consultation to Surgery)
(consider sending patient to Emergency Department)

☐ Severe/Progressive Neurologic Deficit	☐ Cord Compression or Cauda Equina Syndrome

B. Red Flags requiring Urgent CT (immediate radiology consultation recommended)

☐ Suspected Cancer	☐ Suspected Spinal Infection	☐ Suspected Epidural Abscess or Hematoma
☐ Suspected Fracture		

C. Mechanical Spine Pain Syndrome with no Red Flags requiring Non-Urgent CT
(Check all that apply – there MUST be a check in sections 1, 2, and 3 below to meet imaging criteria)

1. ☐ Unbearable Arm or Leg Dominant Pain *(and/or)* ☐ Disabling Neurogenic Claudication *(and/or)* ☐ Functionally Significant Neurologic Deficit

2. ☐ Failure to Respond after 6 weeks of conservative care

3. ☐ Considering Surgery

D. Suspected or Known Conditions *(Check all that apply)*

☐ Cancer *(please specify)*	☐ Intradural Tumour	☐ Bone Tumour or Metastases
☐ Congenital Spine Anomaly	☐ Scoliosis	☐ Spinal Radiation
☐ Demyelination or MS	☐ Inflammatory Disease	☐ Assessment for Vertebroplasty
☐ Prior Spine Surgery *(date)*	☐ Arachnoiditis	☐ Post-operative Collections
☐ Follow-up for a Known Condition *(please specify)*		
☐ Condition Not Listed *(please specify)*		

Prior CT or MRI Spine Imaging (Select one)

☐ CT ☐ MRI
When: _____ Where: _____

Additional Clinical Information

Please provide any additional information below. Please also clearly indicate the affected area on the image to the right.