

ссо

☐ Cancer ☐ No

**PROTOCOL** 

## **OUTPATIENT CT REQUISITION FORM**

**RADIOLOGIST** 

PATIENT INFORMATION							
SURNAME FIRST N						DDLE INITIAL	
JOINTAINE		TIKST WANTE		IVIIL	MIDDLE INTIAL		
ADDRESS				CITY	PROVINCE	POSTAL CODE	
MOBILE PHONE # ALTERNATE P		IONE #	EMAIL				
Patient consents to appointment information being disclosed to them via text of			t or e-mail	☐ Yes, text	t Yes.	e-mail	
SEX ASSIGNED AT BIRTH GENDER IDENTITY				DOB (YYYY/MM/D			
☐ Female ☐ Male ☐ Female ☐ Male ☐ C		Other		,	,		
HEALTH CARD NUMBER (HN)			DE (VC)	DE (VC) WSIB CLAIM # OTHER (Self-pay, research, 3rd party payor)		pay, research, 3rd party payor)	
			TY CONCERNS OR REQUIREMENTS				
Preferred language  ALTERNATE CONTACT CONTACT NAME				CONTACT PHONE #			
(IF NOT PATIENT)	•			CON	TACT FITONE #		
EXAM INFORMATION AND HISTORY							
<b>TEST/REGION(S) TO BE EXAMINED</b> (Choosing Wisely checklists MUST accompany referrals where appropriate i.e. Spine)			<b>REASON</b> presentir	<b>REASON FOR EXAM / CLINICAL HISTORY</b> (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where			
Head			CT availai ECAUTION	(YYYY/MM/DD)  CT availability is limited; requested dates will be accommodated where possible.  CAUTIONS  Known hypersensitivity to contrast agents Currently pregnant Patient cannot provide reliable medical history or provide consent to contrast injections where applicable			
REFERRING PRO					d arrange alternative tra	nsportation.	
PROVIDER NAME				BILLING #		PROFESSIONAL ID	
ADDRESS				CITY	PROVINCE	POSTAL CODE	
PHONE # FAX #				СОРҮ ТО	I		
PROVIDER SIGNATURE				<u>I</u>	DATE		
OFFICE USE ONLY							
PRIORITY  P1 P2 P3 P4 TIMED  Yes No SPECIFIED DATE							