Request for CT Consultation
(Computed Tomography)
HNHB LHIN

Last Name	First Name
HIN/HCN/OHCN/OHIP #	Date of Birth (yyyy/mm/dd)
Address	
City / Province	Postal Code
Phone Number:	Mobile Number:
Gender	Weight (kg) Age

REQUEST TO: **Referral Date:** _____

☐ **Brantford General Hospital**
Phone: 519-751-5545
Fax: 519-752-9983

☐ **Greater Niagara General**
Phone: 905-378-4647
Fax: 905-358-7438

☐ **Haldimand War Memorial Hospital (Dunnville)**
Phone: 905-774-7431
Ext: 1221
Fax: 905-774-7914

☐ **Hamilton General Hospital**
Phone: 905-521-2100
Ext: 49600
Fax: 905-527-9053

☐ **Joseph Brant Hospital**
Phone: 905-336-4126
Fax: 905-336-4148

☐ **Juravinski Hospital & Cancer Centre (Hamilton)**
Phone: 905-389-4411
Ext: 41484
Fax: 905-387-8813

☐ **McMaster University Medical Centre & Children's Hospital (Hamilton)**
Phone: 905-521-2100
Ext: 41484
Fax: 905-521-5086

☐ **Norfolk General Hospital**
Phone: 519-426-0130
Ext: 2219
Fax: 519-429-6892

☐ **St. Catharines Hospital**
Phone: 905-378-4647
Fax: 905-684-6990

☐ **St. Joseph's Healthcare (Hamilton)**
Phone: 905-522-1155
Ext: 35278
Fax: 905-521-6166

☐ **Welland Hospital**
Phone: 905-378-4647
Fax: 905-732-9537

Referring Physician: _____ (Printed Name) _____ (Signature & Designation) Unit: _____ Phone: _____

Hospital/Other Facility: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Send Additional Report to: ☐ Primary Care Physician ☐ Other: _____ (Printed Name) _____ (Phone Number) _____ (Fax)

Exam Payee:
☐ OHIP ☐ WSIB # _____ ☐ Self ☐ Third Party Specify: _____

Patient Routing:
☐ Hospital preference: _____
☐ Next available appointment at any hospital

Exam Requested (be specific):

Current Patient Location:
☐ Inpatient ☐ Outpatient ☐ Emergency

Language Preferred: ☐ English ☐ French ☐ Other: _____
Interpreter Required? ☐ Yes ☐ No

Clinical Information / Relevant History:

Please answer all of the following questions:

1) Known Renal Disease? **YES / NO**
2) Known Diabetes? **YES / NO**
3) On Metformin? **YES / NO**

If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:

eGFR:_____ ml/min/1.73^2 Date (yyyy/mm/dd): _____
Creatinine:_____ ml/min/1.73 Date (yyyy/mm/dd): _____

4) Known Contrast Allergy?
If yes, has the patient been provided with the pre-medication instructions listed below:
☐ Prednisone **50 mg** PO 12 hours and 2 hours pre-procedure
☐ Diphenhydramine **50 mg** PO/IV 1 hour pre-procedure

Relevant tests to date:

Study (e.g. CT/MRI/Xray)	Date (yyyy/mm/dd)	Location

If this is a follow-up exam, please indicate requested date:
_____ (yyyy/mm/dd)

FOR CT USE ONLY

Reviewed by: _____ (Printed Name) _____ (Signature & Designation) Date: _____ (yyyy/mm/dd)

Priority: **1** **2** **T2** **3** **T3** **4** **T4** Test Date: _____ (yyyy/mm/dd) Test Time: _____ (hh:mm)

Clinical Indication: ☐ Cancer ☐ Other: _____

Protocol: _____ Radiologist (printed): _____
Date Protocolled: (yyyy/mm/dd)

Additional Comments: _____ Signature: _____