

# Waterloo Wellington Hospitals CT Requisition

## OFFICE USE ONLY

Exam Date: \_\_\_\_\_  
 Arrival Time: \_\_\_\_\_  
 Exam Time: \_\_\_\_\_

### Fax completed requisition to ONE Hospital:

- |  |                     |  |                     |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> Cambridge Memorial Hospital: (CMH)        | <b>519-740-4904</b> | <input type="checkbox"/> Guelph General Hospital: (GGH)      | <b>519-766-9982</b> |
| <input type="checkbox"/> Grand River Hospital: (GRH)               | <b>519-749-4296</b> | <input type="checkbox"/> St. Mary's General Hospital: (SMGH) | <b>519-749-6513</b> |
| <input type="checkbox"/> Groves Memorial Community Hospital:(GMCH) | <b>519-787-4405</b> |  |                     |

<b>Patient Information</b>		<b>Other Reqs Associated to Patient?</b> <input type="checkbox"/> Y <input type="checkbox"/> N	
Last Name, First Name: _____		Health Card #: _____	VC: _____
DOB: DD/MM/YYYY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		WSIB? <input type="checkbox"/> Y <input type="checkbox"/> N	Injury Date: DD/MM/YYYY
Street Address: _____		Please include Claim #: _____	
City/Town: _____		Other Insurance? Third Party or Self Pay	
Province: _____ Postal Code: _____		Specify: _____	
Contact Number: _____ Email: _____		<b>Required Patient Information:</b>	
Home: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		Height: _____ (cm)	Weight: _____ (kg)
Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message		<input type="checkbox"/> Restricted Mobility	<input type="checkbox"/> Outpatient
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		<input type="checkbox"/> Pediatric Under 10 yrs	<input type="checkbox"/> In-Patient Rm/Loc
<input type="checkbox"/> Y <input type="checkbox"/> N An interpreter is required to consent to the procedure. CMH, GGH, GRH and SMGH have interpretation services available.			

<b>EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUISITIONS WILL BE RETURNED**</b>			
Ordering Physician Name (Please print): _____		<b>Urgency</b>	
Contact #: _____ Fax#: _____		Signature _____	<input type="checkbox"/> Urgent
		Date _____	<input type="checkbox"/> Semi-Urgent
			<input type="checkbox"/> Routine

Copy to (Please print)																																			
<b>Region/Organ of Interest:</b>  <b>Clinical History/Indication (reason for exam):</b>  <b>Previous Relevant Imaging and Surgery (please specify):</b>	<table border="1" style="width:100%"> <tr> <th colspan="2" style="text-align:center">Patient Safety Screening (physician to complete with patient)</th> </tr> <tr> <td>Allergy to x-ray dye/contrast</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">If yes, please describe type of reaction: _____</td> </tr> <tr> <td>Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N LMP (specify) DD/MM/YYYY</td> <td></td> </tr> <tr> <td>Breastfeeding</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td colspan="2"><b>Renal Assessment**:</b></td> </tr> <tr> <td>Kidney problems/disease</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Prior Kidney Surgery</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Dialysis</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>High Blood Pressure/ Cardiovascular disease/Stroke/TIA</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Diabetes Mellitus</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>If yes, is patient on Metformin/Glucophage</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Past/Current treatment with NSAIDs, Diuretics, Chemotherapy or other Nephrotoxic drugs</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Greater than 60 yrs of age</td> <td style="text-align:right"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td colspan="2"><b>**If you answered yes to any of the above, a creatinine and eGFR within the last 3 months must be provided</b></td> </tr> <tr> <td>Creatinine: _____</td> <td>Date: _____</td> </tr> <tr> <td>eGFR: _____</td> <td>Date: _____</td> </tr> </table>	Patient Safety Screening (physician to complete with patient)		Allergy to x-ray dye/contrast	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please describe type of reaction: _____		Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N LMP (specify) DD/MM/YYYY		Breastfeeding	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Renal Assessment**:</b>		Kidney problems/disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Prior Kidney Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure/ Cardiovascular disease/Stroke/TIA	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes Mellitus	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, is patient on Metformin/Glucophage	<input type="checkbox"/> Y <input type="checkbox"/> N	Past/Current treatment with NSAIDs, Diuretics, Chemotherapy or other Nephrotoxic drugs	<input type="checkbox"/> Y <input type="checkbox"/> N	Greater than 60 yrs of age	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>**If you answered yes to any of the above, a creatinine and eGFR within the last 3 months must be provided</b>		Creatinine: _____	Date: _____	eGFR: _____	Date: _____
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<b>Protocol:</b>  Initial: Rad _____ Tech _____	<b>WTIS Priority</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 T: _____	<b>WTIS Reason</b> <input type="checkbox"/> Staging/Diagnosis Ca <input type="checkbox"/> Other <b>Requisition Received Date and Time:</b> _____ DD / MM / YYYY _____ HR / MM

## Please indicate location of Imaging examination for Patient:

<b>Cambridge Memorial Hospital</b> 700 Coronation Blvd. Cambridge ON N1R 3G2	Telephone: 519-621-2333 x2244 Fax: 519-740-4904 www.cmh.org	<ul style="list-style-type: none"><li>• CT Service is located in the hospital's Diagnostic Imaging Department the <b>1<sup>st</sup> Floor</b> of the hospital's <b>A Wing</b>. All patients are asked to register in the department at their arrival time.</li></ul>
<b>Grand River Hospital</b> 835 King St. W Kitchener ON N2G 1G3	Telephone: 519-749-4262 Fax: 519-749-4296 www.grhosp.on.ca	<ul style="list-style-type: none"><li>• CT Service is located in the hospital's Department of Medical Imaging on the <b>2<sup>nd</sup> Floor</b> of the hospital's <b>D Wing</b>. All patients are asked to register in the department at their arrival time.</li></ul>
<b>Groves Memorial Community Hospital</b> 235 Union St. Fergus ON N1M 1W3	Telephone: 519-843-2010 xt.3356 Fax: 519-787-4405 www.gmch.ca	<ul style="list-style-type: none"><li>• All patients are to register in the hospital's Central Registration, located on the Ground Floor, at the indicated arrival time.</li></ul>
<b>Guelph General Hospital</b> 115 Delhi St. Guelph ON N1E 4J4	Telephone: 519-837-6413 Fax: 519-766-9982 www.gghorg.ca	<ul style="list-style-type: none"><li>• CT Service is located in the hospital's Diagnostic Imaging Department on the <b>3<sup>rd</sup> Floor</b> of the hospital. All patients are asked to register in the department at their arrival time.</li></ul>
<b>St. Mary's General Hospital</b> 911 Queen's Blvd Kitchener ON N2M 1B2	Telephone: 519-749-6455 Fax: 519-749-6513 www.smgh.ca	<ul style="list-style-type: none"><li>• CT Service is located in the hospital's Diagnostic Imaging Department on the <b>1<sup>st</sup> Floor</b>. All patients are asked to register in the department at their arrival time.</li></ul>

### Exam Preparation

<b>Cambridge Memorial Hospital</b>	<p><b>Abdomen/Pelvis:</b> Pick up E-Z-Cat in Diagnostic Imaging Department at least 1 day prior to exam date. Nothing to eat 4 hours prior to exam time. Start drinking E-Z-Cat 1 hour prior to exam time. Drink completely ½ hour before exam time.</p> <p><b>Small Bowel Enterography and Colonography:</b> Pick up instructions from your physician or from the Diagnostic Imaging Department at the hospital at least 3 days prior to the exam date</p> <p><b>All other exams:</b> Nothing to eat 4 hours prior to exam.</p>
<b>Grand River Hospital</b>	<p><b>All Exams:</b> No solid foods 4 hours prior to exam time.</p> <p><b>Pediatric patients with sedation:</b> Nothing to eat or drink 4 hours prior to exam time</p> <p><b>Pediatric patients without sedation:</b> Nothing to eat or drink 2 hours prior to exam time</p> <p><b>Colonography:</b> Instruction sheets will be mailed to patient</p>
<b>Groves Memorial Community Hospital</b>  <b>and</b> <b>Guelph General Hospital</b>	<p><b>All exams:</b> Nothing to eat 3 hours prior to exam. Drink 2 x 12oz glasses of water prior to exam. You may void as needed as a full bladder is not required for this exam.</p> <p><b>Abdomen/Pelvis:</b> Pick up Readicat in Diagnostic Imaging Department at least 1 day prior to exam date. Nothing to eat 3 hours prior to exam time. Start drinking Readicat 2 hours prior to exam time. Drink slowly to finish ½ hour before exam time.</p> <p><b>Small Bowel Enterography:</b> Exam will last up to 1.5 hours. Clear fluids only for 24 hours. Take 1 bottle of Citromag (296 ml) at 4:00 pm the day before the examination. Citromag can be purchased at the pharmacy.</p> <p><b>Colonography:</b> Pick up prep and instructions from the Diagnostic Imaging Department at the hospital at least 3 days prior to the exam date</p>
<b>St. Mary's Hospital</b>	<p><b>All Exams:</b> No solid foods 4 hours prior to exam time.</p>

### Important

- Please bring your **Ontario Health Card** and this form to your appointment
- **Patients must be able to consent to the procedure. If language is a barrier, please bring an interpreter.**
- You will be asked to remove any metal, jewelry, piercings that are in the area of the body part being imaged
- If you are unable to keep your appointment, please give us 24 hours' notice
- We kindly ask that you do not wear or apply fragrances in support of our Fragrance Free policies.