CT Consultation/Demande de consultation CT

Timmins and District Hospital / Hôpital de Timmins et du district

John P. Larche Medical Imaging & Cardiopulmonary Department

Service d'imagerie médicale et de soins cardio-pulmonaires John P. Larche

Phone: 705-267-6312 **Fax:** 705-267-6346 **E-mail:** imaging@tadh.com

Patient Name: _____

Date of Birth: _____ (dd / mm / yyyy) **Weight (lbs/kg):** _____ (for medication on some procedures)

Address: _____ **Apt. #:** _____

City: _____ **Postal Code:** _____

Phone (Home): _____ **Work:** _____

Health Card #: _____

SIN #: (for WCB Claims) **Claim #:**

PRECAUTIONS

DROPLET ☐

AIRBORNE ☐

CONTACT ☐

HOSPITAL USE ONLY

Allergies:

Clinical Indication for Exam: Enter all clinical information:

Ordering Physician:

Signature: Date:

Address:

Tel: Fax:

Copy to Family Physician: Dr. Tel. #:

Copy to Other Physician: Dr. Tel. #:

- ☐ Brain
- ☐ Facial and Sinus
- ☐ Neck
- ☐ Chest
- ☐ Abdominal Pelvis
- ☐ Pelvis
- ☐ Colon

Angiogram:

- ☐ Head
- ☐ Carotid
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ Extremity

Spine: ☐ Cervical ☐ Thoracic ☐ Lumbar

- ☐ Upper Extremity
- ☐ Lower Extremity

☐ Special Procedure / Biopsy (Indicate)

_____

_____

_____

Creatinine/eGFR: Order if patient has one or more risks

☐ Greater than 60 years of age	☐ Renal Surgery
☐ Dialysis	☐ Diabetes Mellitus
☐ Renal Transplant	☐ High blood pressure requiring medical therapy
☐ Single Kidney	** Do not discontinue Metformin
☐ Renal Cancer	

FOR RADIOLOGIST USE ONLY/RESERVÉ AU RADIOLOGUE

	CLINICAL INDICATION FOR SCAN	
	BC ☐ **MRI Breast Screening**	
	OT ☐ **Other**	
	SD ☐ **Cancer Staging/Diagnosis**	

DIAGNOSTIC IMAGING - MRI and CT Priority Assessment Tool

Priority Level	Descriptions	Access Target
1 ☐	Emergent	Immediate
2 ☐	Inpatient	Within 48 hours
	Urgent	
3 ☐	Semi-Urgent	Within 10 days
4 ☐	Non-Urgent	Within 4 weeks

Contrast Yes/Oui ☐ No/Non ☐

For TDH Schedulers Only

Réservé aux commis au rendez-vous de HTD

Date Requisition Received/ _____

Date de réception de la l'examen

Scheduled Exam Date/ _____

Date de l'examen

Exam Time _____

Heure de l'examen

Department Use Only	Tech Initials	Patient's Risk of Pregnancy	LMP	Patient's Initials	Examination Date Day	Month	Year	
		☐ Yes ☐ No						☐ In Patient ☐ Out Patient ☐ Portable