MRHA Mississippi River Health Alliance
Almonte General Hospital

Almonte General CT Requisition

613-256-2514 ext.2121

Date: _____

Patient Name: _____

MRN: _____ **DOB:** _____

OHIP: _____

Contact Info: _____

*Requisition must be **fully** completed before an examination can be scheduled*

All requests are to be faxed and the patient will be contacted for an appointment.
Fax completed requisition to CT Bookings at **613-256-5932**

EXAMINATION REQUESTED: _____

History and Clinical Findings (PLEASE PRINT CLEARLY)

Location: ☐Outpatient ☐Emergency _____
☐Inpatient Unit _____

Ambulation: ☐Ambulatory ☐Wheelchair ☐Stretcher
Precautions: ☐None ☐Contact ☐Droplet ☐Airborne

Note: maximum weight: 500 lb (227 kg)
Pregnant: ☐ YES ☐ NO
Allergy to Iodine: ☐ YES ☐ NO

Contrast Induced Nephropathy Screening
Chronic kidney disease or transplant: ☐ YES ☐ NO
Followed by Urology / Nephrology: ☐ YES ☐ NO
If YES to either, must provide (within 6 months):
eGFR: _____ **Date drawn** _____

Ordering Physician (PRINT): _____

Copy of Report to (PRINT): _____

_____

Physician's Signature: _____**Billing#**_____**Phone#**_____

FOR INTERNAL USE ONLY:

Radiologist Protocol:

Priority code: P1 P2 P3 P4

D1 _____/_____/_____

D2 _____/_____/_____

D3_____/_____/_____

Timed: Y N

Sys Delay: Y N