Central Intake Ontario
Central Diagnostic Imaging Hub
Diagnostic Imaging CT/MRI

Referral Intake Fax Line: (905) 780- 2581

HOSPITAL ID: _____

OUTPATIENT CT REQUISITION FORM

PATIENT INFORMATION

SURNAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	PROVINCE	POSTAL CODE

MOBILE PHONE #	ALTERNATE PHONE #	EMAIL

Patient consents to appointment information being disclosed to them via text or e-mail ☐ Yes, text ☐ Yes, e-mail

SEX ASSIGNED AT BIRTH ☐ Female ☐ Male	GENDER IDENTITY ☐ Female ☐ Male ☐ Other	DOB (YYYY/MM/DD)	HEIGHT(CM)	WEIGHT (KG)

HEALTH CARD NUMBER (HN)	VERSION CODE (VC)	WSIB CLAIM #	OTHER (self-pay, research, 3rd party payor)

☐ INTERPRETER REQUIRED Preferred language	ACCESSIBILITY CONCERNS OR REQUIREMENTS

ALTERNATE CONTACT (IF NOT PATIENT)	CONTACT NAME	CONTACT PHONE #

EXAM INFORMATION AND HISTORY

TEST/REGION(S) TO BE EXAMINED

- ☐ **Head**
  - ☐ Brain
  - ☐ Sinuses
  - ☐ Facial Bones
  - ☐ Temporal Bones
  - ☐ Orbits
  - ☐ Circle of Wilis
- ☐ **Neck**
  - ☐ Routine
  - ☐ Carotids
- ☐ **Spine**
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
  - ☐ Sacral/Coccyx
- ☐ **Thorax**
  - ☐ Routine
  - ☐ High-resolution
  - ☐ Pulmonary Embolism
- ☐ **Thorax/Abdomen /Pelvis**
- ☐ **Abdomen/Pelvis**
  - ☐ Routine
  - ☐ Renal Colic
  - ☐ Urography
  - ☐ Enterography
- ☐ **Musculoskeletal** (please indicate)

☐ **OTHER EXAM TYPE** (please indicate)

REASON FOR EXAM /CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)

If the patient requires emergent attention, do not submit this form to Central Intake. Please contact your nearest imaging facility directly

☐ **TIMED FOLLOW UP** **DATE REQUESTED** (YYYY/MM/DD)

CT availability is limited: requested dates will be accommodated where possible.

SCREENING & PRECAUTIONS

RENAL ASSESSMENT

- ☐ No known kidney issues
- ☐ Yes, patient has kidney problems, kidney transplant or is seeing a urologist

If yes, check all that apply: ☐ Has diabetes ☐ On dialysis

Please provide the most recent eGFR results (within the last 6 months)

eGFR RESULT (ml/min/1.73^2) **DATE COLLECTED** (YYYY/MM/DD)

- ☐ Known hypersensitivity to contrast agents
- ☐ Currently pregnant
- ☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable
- ☐ Requires general anesthesia
  Rationale

For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.

PREFERRED LOCATION

All patients will be triaged to the shortest distance unless a preferred location is entered.	PREFERRED LOCATION(S)

OTHER ROUTING CONSIDERATIONS

REFERRING PROVIDER

PROVIDER NAME		BILLING #		PROFESSIONAL ID

ADDRESS	CITY	PROVINCE.	POSTAL CODE

PHONE #	FAX #	COPY TO

PROVIDER SIGNATURE	DATE

OFFICE USE ONLY

PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED ☐ Yes ☐ No	SPECIFIED DATE

OH ☐ Cancer ☐ No	PROTOCOL	RADIOLOGIST