PRHC Diagnostic Imaging Services
C.T. Requisition

Fax: 705-876-5046

PATIENT LABEL

CLIENT/PATIENT INFORMATION		
Name:	DOB (DD/MM/YYYY):	☐ Male ☐ Female
Health Card #:	Phone #:	
Address:	City:	Postal Code:
☐ Inpatient ☐ Outpatient ☐ Wheelchair ☐ Ambulatory ☐ Non Ambulatory		
Hospital:	Transportation: ☐ Ambulance ☐ Car	
Is this WSIB? ☐ Yes ☐ No Claim #:		

SCAN REQUESTED
Area to be scanned:
History/Clinical Information (relevant to exam requested):
Previous related imaging: ☐ Yes ☐ No If yes where:

PHYSICIAN INFORMATION	
Referring Physician:	
Phone #:	
Fax #:	
Billing #:	CPSO #:
Physician Signature:	

REPORTS TO
Dr.
Dr.
Dr.

INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED

Risks for contrast induced Nephropathy

Blood-work is required and must be included with CT request for patients with any of the following:

☐ Known renal dysfunction	Notes:
☐ Dialysis	

If Yes:

Creatinine :__________ (u mol/L) *eGFR: __________ (ml/min)

Date drawn (DD/MM/YYYY): ______________________________

Outpatients required blood-work within 90 days of exam date)

Was consent obtained? ☐ Yes ☐ No

Previous adverse reaction to contrast (x-ray dye)? ☐ Yes ☐ No

If yes, explain:

Possibility of pregnancy? ☐ Yes ☐ No

Ordering Physician Signature:	**Date (DD/MM/YYYY):**

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Form #2219, Revised Sepetmber, 2023

PRHC
Peterborough Regional
Health Centre