KEMPTVILLE DISTRICT HOSPITAL
Building healthier communities

CT Requisition

Booking Clerk: (613)258-6133 ext.415
FAX: (613)258-4997

PATIENT STICKER

INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED AND MAY DELAY STUDY

Health Card #_____ **Location:** ☐ **Outpatient** ☐ **Emergency** ☐ **Inpatient:** _____

Surname:_____ **Date of Birth:**_____ ☐ **Female** ☐ **Male**

First Name:_____ **Address:** _____

Phone Number - Preferred:_____ **Cell#**_____

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

Allergies:_____
LMP:_____

CT Examination Requested: (500lbs CT patient weight limit)

☐ Abdomen ☐Head ☐C-Spine ☐Extremity/MSK
☐ Pelvis ☐Neck ☐T-Spine ☐ Other _____
☐ Chest/Thorax ☐Facial Bones/Sinus ☐L-Spine

Clinical Information/Reason for Exam:

Blood work requirements:
Does your patient have any history of renal disease? ☐**YES** ☐ **NO**
If the patient meets the above criteria, **bloodwork is REQUIRED** Within 6 months for outpatients, within 7 days for inpatients, or within 24 hours for acutely ill patients.
eGFR:_____(mL/min) Date Drawn:_____

Physician Name:_____ Signature: _____

Physician's Billing Number:_____ Date Requisition Completed: _____

Copy Report to: _____

CT Protocol: **FOR IMAGING USE ONLY**

IV: ☐ **C-** ☐ **C+** ☐ **C+ / C-**

Oral: ☐ None ☐Water Only ☐Water Based Contrast

Signature of Radiologist/Technologist:_____ ☐ Pre-Medication if allergic to iodine/contrast

Priority: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **4N**
Same Day **< 48hrs** **<10 Days** **<28 Days** **Next Available Slot**

Verified 2 patient ID's by: [ ]DOB or [ ]Armband or [ ] Name or [ ] Other

February 12, 2025
Form #1439