ST. JOSEPH'S HEALTH CENTRE | TORONTO

CT (CONTRAST AND NON-CONTRAST), INTERVENTIONAL, AND BIOPSY

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

Name: _____
Male ☐ Female ☐
MRN : _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

EXAMINATION(S) REQUESTED ☐ **STAT/TODAY (Call CT or Vascular Radiologist)** ☐ **URGENT** ☐ **ROUTINE**

CT Scan: _____ Interventional/Vascular/Biopsy: _____

Current Patient Location: ☐ Outpatient ☐ Clinic/ACC ☐ Emergency ☐ Inpatient
Study to be Done as: ☐ Outpatient ☐ Inpatient

WSIB/Third Party Claim Number: _____

CLINICAL HISTORY

Isolation Precautions: ☐ **N/A** ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Reverse**
Allergy to Intravenous Contrast: ☐ **NO** ☐ **YES (If yes, contact DI for pre-medication)**

CT SCAN (Contrast Enhanced Only) and INTERVENTIONAL PROCEDURES REQUIRING IV CONTRAST

Estimated Glomerular Filtration Rate (eGFR) in mL/min:
For all patients greater than 60 years of age or those at risk for underlying renal and severe liver disease, diabetes, hypertension, solitary kidney, and/or previous organ transplant, complete the following:
IV Contrast Preferred ☐ YES ☐ NO eGFR: _____ (within last 6 weeks).
If eGFR is less than 45: ☐ CIN Protocol Started ☐ CIN Protocol Declined Time Started: _____ Time Ready to Scan: _____
If eGFR is not available, complete the following (required for eGFR calculation):
Creatinine (umol/L) _____ (within last 6 weeks) Age: _____ years Gender: ☐ M ☐ F ☐ Ethnicity: Black

For all patients taking Metformin
☐ Patient has been informed to discontinue Metformin for 48 hours following injection of IV contrast.
☐ Patient has also been informed that a blood test is required after 48 hours to determine whether he/she can resume Metformin.

INTERVENTIONAL/BIOPSY (excluding Breast, Thyroid, Prostate and Superficial Biopsies)
CBC, INR, and PTT within the last 28 days required Results: INR _____ Platelets _____
Date of Labwork: _____ Results on Sunrise ☐ YES ☐ NO Outside Lab (Name): _____

Ordering Physician: Advise patient of (or write order for) the following instructions (SEE PAGE 2/BACK OF THIS PAGE)

ADDITIONAL INFORMATION

Date of Last Menstrual Period: _____ ☐ N/A
☐ Falls Risk ☐ Lifting Device Required
☐ Patient with Restraints (must be accompanied)
Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No
Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No
Contact Telephone Number (if different from above): _____

REQUESTING PHYSICIAN

Address: _____
City: _____
Postal Code: _____
Telephone Number: _____
Fax: _____
Copy to: _____
MD (Physician's Printed Name)

DATE/TIME	**SIGNATURE**	**PRINT NAME**
DD / Month / YYYY ___:___h		

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(DO NOT FAX/SEND THIS PAGE TO DIAGNOSTIC IMAGING)

INTERVENTIONAL AND BIOPSY
(EXCLUDING BREAST, THYROID, PROSTATE, AND SUPERFICIAL BIOPSIES)

Instructions for Ordering Physicians

Advise patient of (or write order for) the following instructions
(if contraindicated, notify Radiologist):

- Acetylsalicylic Acid (Aspirin ®) – Stop taking 5 days before renal biopsy, biliary intervention, and nephrostomy only
- Clopidogrel (Plavix ®) – Stop taking 5 days before
- Pentoxifylline (Trental ®) – Stop taking 5 days before
- Coumadin (Warfarin ®) – Stop taking 5 days before (excluding breast biopsy)
- Low Molecular Weight Heparin – Stop taking 24 hours before
- Heparin – Stop taking 4 hours before