Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

Appointment:

_____

Request For CT Scan

Department of Diagnostic Imaging
Georgian Bay General Hospital
Tel. (705) 526-1300 Ext. 5090
Fax. (705) 526-7837

Name: _____Gender: □ M □ F

Address: _____

City: _____ Postal Code: _____

Health Card #: _____

Date of Birth *(DD/MM/YYYY)*: _____

Home #: _____ Cell #: _____

Please allow 1 week to receive notification of appointment

Section 1: To be completed by the referring physician:

Area to be examined (be specific):

Diagnostic Question/Clinical History:

Are you requesting a timed follow-up procedure (e.g., 6 month follow-up)? If yes, date requested (DD/MM/YYY):

*****Please note that failure to provide pertinent information may delay patient examination.**

Section 2: To be completed by the referring physician with the patient *(pre-screening):*

Risk Factors for Contrast- Induced Acute Kidney Injury (CI-AKI):

History of kidney disease (chronic kidney disease, remote acute kidney injury, kidney surgery, ablation) □ Yes □ No

If YES to the above, a current creatinine (within 3 months of appointment) is required.

Serum Creatinine: Date obtained:

Patient Weight:

Is the patient currently on dialysis? □ Yes □ No
If yes and patient has residual urine output (at least one cup/day), has the patient been cleared for contrast by a nephrologist? □ Yes □ No

Is the patient allergic to CT contrast media? □ Yes □ No
If yes, please describe reaction type and estimate severity:

Is the patient pregnant? □ Yes □ No

Ambulation:

□ Walk □ Wheelchair □ Stretcher □ MEDICAL LIFT

For Radiologist Use ONLY:

Protocol

□ **P1** □ **P2** □ **P3** □ **P4**

□ Ca Stage/Dx □Ca Surveillance □ Breast CA Screen □ Other

CHEST	A_____	B_____	C_____
ABDOMEN	A_____	B_____	C_____
PELVIS	A_____	B_____	C_____
HEAD	A_____	B_____	C_____
COMP HEAD	A_____	B_____	C_____
SPINE	A_____	B_____	C_____
NECK	A_____	B_____	C_____
EXTREMITY	A_____	B_____	C_____

CTA (CT ANGIO): _____

OTHER: _____

RADIOLOGIST SIGNATURE: _____

Section 3: To be completed by the referring physician

Referring Physician (please print): _____
Address: _____ City: _____
Postal Code: _____ Tel# _____ Fax# _____
Physician Signature: _____ Date: _____

INFORMATION FOR C.T. EXAMINATIONS
*****PLEASE READ CAREFULLY*****

Your doctor has requested a C.T. (Computerized Tomography) examination for you, during which X-rays are used to produce information for computers to reconstruct cross-sectional images of various parts of the body.

When you arrive at the hospital, please check in at Central Registration located in the front lobby of the hospital. You will then be directed to the Diagnostic Imaging Department on the main floor.

PLEASE FOLLOW THE INSTRUCTIONS RELEVANT TO YOUR EXAMINATION:

C.T. Scan Head, Chest, Neck or Spine
No preparation

C.T. Scan Abdomen or Pelvis (with contrast)
1. Pick up oral contrast preparation in the Diagnostic Imaging Department at least 2 days prior to your appointment (You will be notified when your appointment is made if you are required to do this)
2. Nothing to eat or drink for 2 HOURS before your appointment time (with the exception of the oral contrast)
3. Be prepared to be in the department for approximately 1-2 hours. Approximately 15 minutes of that time will be spent in the scan room.
4. Emergency patient's take precedence and may cause delays, however, we do our best to remain on schedule.

IF YOU HAVE ALLERGIES, KIDNEY PROBLEMS, DIABETES OR IF THERE IS A CHANCE THAT YOU MIGHT BE PREGNANT, PLEASE TELL THE TECHNOLOGIST OR NURSE WHEN YOU ARRIVE.

If you have to cancel your appointment, please notify us immediately.
To re-book your appointment may take several weeks.
Please call (705) 526-1300 Ext. 5090.

Renseignements relatifs aux examens de TDM
*****Veuillez lire attentivement*****

Votre médecin a demandé que vous passiez un examen de TDM (tomodensitométrie commandée par ordinateur), examen effectué à l'aide de rayons X produisant des informations qui permettent aux ordinateurs de reconstruire des images de coupes axiales de diverses parties du corps.

En arrivant à l'hôpital, veuillez vous présenter à l'inscription centrale qui se trouve à l'entrée principale. On vous orientera vers le Service d'imagerie diagnostique qui se trouve au rez-de-chaussée

Veuillez suivre les instructions qui se rapportent à l'examen qui s'applique à votre cas :

Tomodensitogramme - tête, poitrine, cou ou colonne vertébrale
Aucune préparation requise.

Tomodensitogramme - abdomen ou bassin (avec produit de contraste)
1. Au moins deux jours avant votre rendez-vous, passez prendre la solution de contraste par voie orale au Service d'imagerie diagnostique. (Si vous devez prendre cette solution, on vous avisera au moment de fixer votre rendez-vous.)
2. Ne rien manger ni boire pendant 2 HEURES avant le rendez-vous (à l'exception de la solution de contraste).
3. Soyez prêt à passer 1 à 2 heures au Service d'imagerie. Pendant cette période, vous passerez environ 15 minutes dans la salle de TDM.
4. Les urgences passent en priorité et peuvent occasionner des retards, toutefois, nous nous faisons de notre mieux pour respecter l'horaire fixé.

Si vous souffrez d'allergies, de problèmes rénaux, de diabète, ou si vous croyez qu'il est possible que vous soyez enceinte, veuillez en informer le personnel technique ou infirmier en arrivant.

Si vous devez annuler votre rendez-vous, veuillez nous en informer immédiatement.
Cela peut prendre plusieurs semaines pour réserver un autre rendez-vous.
Veuillez appeler le 705 526-1300, poste 5090.