Alberta Health Services

Computed Tomography (CT) Request

- Fax to Diagnostic Imaging; fax numbers listed at http://www.albertahealthservices.ca/diagnosticimaging
- *Urgent/Emergent requests must be discussed by direct consultation with a radiologist*

Preferred Facility

Patient label here or information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
Address (street, city, province, postal code)	
PHN	Daytime Phone
Inpatient location	WCB Claim Number

Referring Physician (***PRINT*** *first and last name)*	Physician Phone *(required)*	Physician Fax *(required)*	Contact Number for Critical Test Results *(required)*

Signature	Date *(yyyy-Mon-dd)*	Copy to Physician *(first and last)*	Copy to Fax

Specific anatomical area to be examined

Relevant clinical history/presumptive diagnosis

Clinical question to be answered

Relevant Previous Imaging Studies

Location	Type	Date *(yyyy-Mon-dd)*	Attached copy
			☐ No ☐ Yes

Current Patient Condition

Date of LMP *(yyyy-Mon-dd)* | Height ☐ cm ☐ in | Weight ☐ Kg ☐ lbs

Condition	No	Yes	If Yes:
Pediatric/Special Needs	☐	☐	Requires sedation ☐ No ☐ Yes
Isolation Precautions	☐	☐	Specify type:
Diabetic	☐	☐	Metformin *(Glucophage)* ☐ No ☐ Yes ***(Patient may have to stop Metformin for 48 hours post contrast media injection)***
Asthma	☐	☐	n/a
History of a Severe anaphylaxis reaction	☐	☐	Carries an Epipen ☐ No ☐ Yes
Allergies *(include any reaction to contrast media)*	☐	☐	Specify:
Organ Transplant	☐	☐	Specify:
Power Compatible Port/PICC/CVC insitu	☐	☐	Specify:
Mechanical lift/Transfer required	☐	☐	Specify:
Research Study	☐	☐	Study Name: Study Number:

Renal Insufficiency ☐ No ☐ Yes On Dialysis ☐ No ☐ Yes ► run days:	If no current results available, please indicate date ordered *(yyyy-Mon-dd)*

Serum Creatinine *(within 90 days)*	GFR	Date *(yyyy-Mon-dd)*

Department Use Only Date format: *yyyy-Mon-dd* - Time format: *hh:mm*

Date Received	Time Received	Date of Appointment	Time of Appointment

More info required ☐ No ☐ Yes ► Explain:	Protocol: IV Contrast ☐ No ☐ Yes Oral Contrast ☐ No ☐ Yes

Priority ☐ OP1 ☐ OP2 ☐ OP3 ☐ OP4, *Specify date:*	Clerk Initial	Radiologist Name