

PATIENT INFORMATION				
SURNAME		FIRST NAME		MIDDLE INITIAL
ADDRESS			CITY	PROVINCE POSTAL CODE
MOBILE PHONE #		ALTERNATE PHONE #		EMAIL
Patient consents to appointment information being disclosed to them via text or e-mail: <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, email				
SEX ASSIGNED AT BIRTH	GENDER IDENTITY		D.O.B. (YYYY/MM/DD)	HEIGHT (CM) WEIGHT (KG)
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other			
HEALTH CARD #		VERSION CODE (VC)	WSIB CLAIM #	OTHER (Self-pay, research, 3rd party payor)
<input type="checkbox"/> INTERPRETER REQUIRED Preferred language		ACCESSIBILITY CONCERNS OR REQUIREMENTS		
ALTERNATE CONTACT (If not patient)	CONTACT NAME		CONTACT PHONE #	

EXAM INFORMATION AND HISTORY		
TEST/REGION(S) TO BE EXAMINED		REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)
<input type="checkbox"/> HEAD <input type="checkbox"/> Sinuses <input type="checkbox"/> Facial bones <input type="checkbox"/> Temporal bones <input type="checkbox"/> Orbits <input type="checkbox"/> Circle of Willis <input type="checkbox"/> NECK <input type="checkbox"/> Routine <input type="checkbox"/> Carotids <input type="checkbox"/> OTHER EXAM TYPE (Please indicate)		<input type="checkbox"/> SPINE <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacral / Coccyx <input type="checkbox"/> THORAX <input type="checkbox"/> Routine <input type="checkbox"/> High-resolution Pulmonary Embolism <input type="checkbox"/> THORAX / ABDOMEN / PELVIS <input type="checkbox"/> ABDOMEN / PELVIS <input type="checkbox"/> Routine <input type="checkbox"/> Renal Colic <input type="checkbox"/> Urography <input type="checkbox"/> Enterography <input type="checkbox"/> MUSCULOSKELETAL (please indicate)
		<input type="checkbox"/> TIMED FOLLOW UP DATE REQUESTED (YYYY/MM/DD)
<i>CT availability is limited; requested dates will be accommodated where possible.</i>		

SCREENING AND PRECAUTIONS		
RENAL ASSESSMENT <input type="checkbox"/> No known kidney issues <input type="checkbox"/> Yes, patient has impaired renal function or a history of renal transplant If yes, check all that apply: <input type="checkbox"/> Has diabetes <input type="checkbox"/> On dialysis Please provide the most recent eGFR results (within the past 6 months) eGFR RESULT (ml/min/1.73 ²) _____ DATE COLLECTED (YYYY/MM/DD) _____		<input type="checkbox"/> Known hypersensitivity to contrast agents <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Patient cannot provide reliable medical history or provide consent to contrast injections where applicable <input type="checkbox"/> Requires general anesthesia Rationale: _____ <i>For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.</i>

REFERRING PROVIDER			
PROVIDER NAME		BILLING #	PROFESSIONAL ID
ADDRESS		CITY	PROVINCE POSTAL CODE
PHONE #	FAX #	COPY TO	
PROVIDER SIGNATURE			DATE

HOSPITAL LOCATION – MUST BE SELECTED			
Select the hospital you would send this patient to, given their diagnostic imaging requirements. Patient will be directed to reasonable nearest hospital with lowest wait times:			
<input type="checkbox"/> Alexandra Marine and General Hospital <input type="checkbox"/> Bluewater Health <input type="checkbox"/> Brant Community Healthcare System <input type="checkbox"/> Brightshores Health System <input type="checkbox"/> Cambridge Memorial Hospital <input type="checkbox"/> Chatham-Kent Health Alliance <input type="checkbox"/> Erie Shores Healthcare	<input type="checkbox"/> Guelph General Hospital <input type="checkbox"/> Haldimand War Memorial Hospital <input type="checkbox"/> Hamilton Health Sciences <input type="checkbox"/> Hanover and District Hospital <input type="checkbox"/> Huron Perth Healthcare Alliance <input type="checkbox"/> Joseph Brant Hospital <input type="checkbox"/> Listowel Wingham Hospital Alliance	<input type="checkbox"/> London Health Sciences Centre <input type="checkbox"/> Niagara Health System <input type="checkbox"/> Norfolk General Hospital <input type="checkbox"/> South Bruce Grey Health Centre <input type="checkbox"/> St Joseph's Health Care - London <input type="checkbox"/> St Joseph's Healthcare - Hamilton <input type="checkbox"/> St Thomas-Elgin General Hospital	<input type="checkbox"/> Strathroy Middlesex General Hospital <input type="checkbox"/> Tillsonburg District Memorial Hospital <input type="checkbox"/> Waterloo Regional Health Network <input type="checkbox"/> Wellington Health Care Alliance <input type="checkbox"/> Windsor Regional Hospital <input type="checkbox"/> Woodstock Hospital
<input type="checkbox"/> Patient must go to selected hospital. This may result in longer wait times.			

OFFICE USE ONLY			
PRIORITY <input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4		TIMED <input type="checkbox"/> YES <input type="checkbox"/> NO	SPECIFIED DATE
CCO	PROTOCOL		RADIOLOGIST