Alberta Health Services

Computed Tomography (CT) Request

- All fields must be completed in order to process 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

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Preferred Facility		Inpatient Location
Patient Phone Number *(Cell # preferred)*		Patient Address
City	Postal Code	WCB Claim Number
Ordering Provider Name	Provider ID	Department ID
Provider Fax	Provider Phone	Contact Number for Critical Test Results
Provider Address/Location	City	Postal Code
Locum ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____		
Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last,first and middle)* / Copy to Fax
Requested Procedure	Research Study ☐ No ☐ Yes Study Name: _____ Study #: _____	
Reason for Exam		
Clinical question to be answered		

Relevant Previous Imaging Studies

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

Current Patient Condition	**No**	**Yes**	***Weight*** _____ ☐ Kg ☐ lbs ***Height*** _____ ☐ cm ☐ in
Pregnant ☐ n/a	☐	☐	Date of LMP *(dd-Mon-yyyy)*
Pediatric/Special Needs	☐	☐	Requires sedation ☐ No ☐ Yes ☐ Anesthesia
Isolation Precautions	☐	☐	Specify:
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:
Previous chemotherapy	☐	☐	Specify:
Power Compatible Port/PICC/CVC insitu	☐	☐	Specify:
Mechanical lift/Transfer required	☐	☐	Specify:
Vascular Disease (Hypertension, HF, etc)	☐	☐	Specify:
Renal Disease or Solitary Kidney	☐	☐	Specify:
Renal Insufficiency	☐	☐	Date of last GFR Result *(dd-Mon-yyyy)*

On Dialysis ☐ No ☐ Yes ► ☐ Hemodialysis ☐ Peritoneal Dialysis ► ☐ Acute Renal Failure ☐ End Stage Renal Disease

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

Department Use Only

Date Received *(dd-Mon-yyyy)*	Time Received *(hh:mm)*	Date of Appointment *(dd-Mon-yyyy)*	Time of Appointment *(hh:mm)*

More info required ☐ No ☐ Yes ► Explain:

Protocol: IV Contrast ☐ No ☐ Yes
Oral Contrast ☐ No ☐ Yes

Priority ☐ OP1 ☐ OP2 ☐ OP3 ☐ OP4, Specify date: Radiologist