

CAT (CT) SCAN REQUISITION

Name	Date of Birth (mm/dd/yy)	Sex	Weight
Address	City	Province	Postal Code
Home Phone	Work Phone	WCB#	ICBC#
Known Allergies	Priority:	Routine Semi-Urgent STAT	Date

SAFETY

Has the patient previously had injection of iodinated contrast for CT or IVP?	YES	NO
Is the patient able to lie flat for 45 minutes?	YES	NO
Is the patient Claustrophobic?	YES	NO
Is the patient diabetic?	YES	NO
Is the patient pregnant or breastfeeding?	YES	NO
Has the patient had a barium study?	YES	NO
Relevant Previous Studies: _____		

AREA/TYPE OF EXAMINATION

With Contrast?	YES	NO			
<input type="checkbox"/> NASOPHARYNX/NECK (ENT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> TM JOINTS	<input type="checkbox"/> SINUSES	<input type="checkbox"/> PAROTIDS
<input type="checkbox"/> MASTOIDS/IAC/TEMPORAL BONES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PELVIS	<input type="checkbox"/> SI JOINTS	<input type="checkbox"/> ORBITS
<input type="checkbox"/> SELLA TURCICA(PITUITARY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> FACIAL BONES	<input type="checkbox"/> BRAIN	
<input type="checkbox"/> CERVICAL SPINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> LUMBAR SPINE	<input type="checkbox"/> CTA: (SPECIFY) _____	
<input type="checkbox"/> MSK (specify): _____			OTHER (specify): _____		

HISTORY

History and Clinical Diagnosis: (Please Include prior surgery, special instructions if any)	List Previous Relevant Exams, (please submit images & reports).
	1 2 3 4

CHIROPRACTOR INFORMATION (requisition will be returned if name or license # is illegible)

Referring Chiropractor (please print): _____

Referring Chiropractor Signature (required): _____

College License #: _____ Phone#: _____ Fax#: _____

Additional Copies: _____

OFFICE USE ONLY

Date of Exam: ____ / ____ / ____	Time: _____	Contrast: _____ mls.	Initials: _____
Protocol:	Contrast? YES NO		
	Priority: _____		



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