Hamilton Health Sciences

REQUEST FOR CT CONSULTATION

REQUEST TO: ☐ HGH ☐ JHCC ☐ MUMC/MCH

(Site legend and contact information on back of form)

DATE (yyyy/mm/dd) _____ **Patient's Weight** _____ kg

Current Patient Location:

☐ Inpatient ☐ Outpatient ☐ Emergency

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

REFERRING PHYSICIAN: (printed name) _____ Phone _____ ext._____

(signature) _____ Pager _____

Exam Requested: _____ **Contrast:** ☐ C+ ☐ C- ☐ Unknown

Start IV as required for test

Clinical Information / Relevant History _____

_____

_____

_____

_____

Clinical Questions: Please answer the following.

Does the patient have known Renal Disease? ☐ No ☐ Yes

Does the patient have known Diabetes? ☐ No ☐ Yes

Is the patient on Metformin? ☐ No ☐ Yes

If **YES** to any of these 3, please provide an eGFR within 90 days for outpatient and 7 days for inpatient

eGFR:_____ mL/min/1.73^2

Date (yyyy/mm/dd) _____

Is there a known Contrast Allergy? ☐ No ☐ Yes → If **YES**, provide patient with pre-medication as below:

Is this a Pediatric Patient? ☐ No ☐ Yes

If **YES**, are there any special considerations:

☐ Sedation

☐ GA (consult with Anesthesia is required)

☐ Other _____

Study (e.g. CT/MRI/X-ray)	Date (yyyy/mm/dd)	Location

For Routine Outpatients:

- predni**SONE 50 mg** PO 13 hours and 7 hours pre scan and 1 hour before contrast administration **and**
- diphenhydr**AMINE 50 mg** PO 1 hour before contrast administration

For Routine Inpatients: • See Order Set

For ED Patients:

- hydrocortisone 200 mg IV 1 hour pre scan **or**
- methyl**PREDNIS**olone 40 mg IV 1 hour pre scan **and**
- diphenhydr**AMINE** 50 mg IV 1 hour pre scan

FOR CT USE ONLY

2 Patient Identifiers: ☐ DOB ☐ Armband ☐ Address **Patient Pregnant:** ☐ No ☐ Yes

Consent Obtained: ☐ N/A ☐ Verbal ☐ Written ☐ Emergency ☐ POW

Valuables Removed AND Returned ☐

Apron/shielding provided _____ Protocolled by: _____

MRT Notes _____

_____

Medical Radiation Technologist (MRT) _____ _____ _____

(printed name) (signature) Date (yyyy/mm/dd)

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Site Legend and Contact Information

HGH = **Hamilton General Hospital**
237 Barton St. E.
Hamilton, Ontario L8L 2X2

Outpatient → Phone: 905-521-2100 Ext 46900 Fax: 905-527-9053

Inpatient → Intake Nurse Pager # 7223 Fax: 905-577-8020
(Monday - Friday 0800-1600)

After Hours (Monday to Friday 1800-0800, weekends and statutory holidays)
Page Radiologist on call through central paging

JHCC = **Juravinski Hospital & Cancer Centre**
711 Concession St.
Hamilton, ON L8V 1C3

Outpatient → Phone: 905-521-2100 Ext 41484 Fax: 905-387-8813

Inpatient → Intake Nurse Pager # 1218 Fax: 905-381-7036
(Monday - Friday 0900-1700)

After Hours (Monday to Friday 1800-0800, weekends and statutory holidays)
Page Radiologist on call through central paging

MUMC/MCH = **McMaster University Medical Centre & Children's Hospital**
1200 Main St. W.
Hamilton, ON L8N 3Z5

Outpatient → Phone: 905-521-2100 Ext 41484 Fax: 905-521-5086

Inpatient → Phone: 905-521-2100 Ext 73728 Fax: 905-521-2647

After Hours page on-call pediatric radiologist Pager # 76443

✳ All referrals are routed through a central booking office and reviewed by a radiologist to ensure the requested site is the most appropriate for both the patient and the requested investigation intent of the CT and following review, the appointment will be booked at the most appropriate site which may differ from the original requested site.