Interior Health

COMPUTERIZED TOMOGRAPHY (CT) REQUISITION

Patient Name *(last)* _____

(first) _____

DOB *(dd/mmm/yyyy)* _____

PHN _____ MRN _____

Account / Visit # _____

IH USE ONLY

BOOKING OFFICE USE	Appointment Date:	Time:	Date received:

IMPORTANT: Incomplete or illegible forms will be returned. Exam will be delayed or cancelled.

Patient name *(last)* _____ *(first)* _____

DOB *(dd/mmm/yyyy)* _____ PHN _____

Patient Address _____

City / Town _____ Province _____ Postal Code _____

Phone _____ Cell Phone _____

Patient Height _____ Patient Weight _____ Pregnant: ☐ Yes ☐ No Birth Sex: ☐ F ☐ M ☐ Unknown

Unavailable dates _____

Billable to: ☐ MSP ☐ ICBC ☐ WorkSafeBC Claim # _____ ☐ Patient ☐ Other _____

☐ **Ambulatory** ☐ **Wheelchair** ☐ **Mechanical lift**

PRIORITY LEVEL Priority Descriptions on reverse side

☐ P1 Emergent *(Physician must speak with radiologist)*

☐ P2 Urgent ☐ P3 Semi-urgent ☐ P4 Non-urgent

☐ P5 Date Specific _____

Name of ordering Practitioner & MSP Practitioner Number

Ordering Practitioner Phone:

EXAM REQUESTED:

Tentative Diagnosis / Reason for Exam / Pertinent History *(include relevant imaging / lab results and date/location performed)*

This exam may require IV Contrast Media. The following questions MUST BE ANSWERED:

Does your patient have:

Known or suspected Renal Disease / Renal Failure or a Renal Transplant?

☐ **YES** - Creatinine and eGFR are required within 90 days of appointment – please arrange

☐ **NO** - No blood work required

Does your patient have:

A Central Venous Access Device? ☐ **NO** ☐ **YES** Type: _____

A previous reaction to Contrast Media? ☐ **NO** ☐ **YES** Explain: _____

Creatinine (µmol / L):

eGFR (mL / min):

Date:

Pediatric Patient (under 17 years) ☐ **NO** ☐ **YES**

If YES, Sedation Required? ☐ **NO** ☐ **YES**

Date (dd / mmm / yyyy)	Time (24 hour)	Provider Name / Signature	Initials	Designation / College ID #

Copy Results To:

FOR MEDICAL IMAGING DEPARTMENT USE ONLY

For Radiologist's Use Only: ☐ Non-Contrast ☐ IV Contrast ☐ Oral Prep ☐ Water Prep

Protocol / Instructions _____

Radiologist Name _____

Clear Form Print Form

CT REQUISITION

Permanent part of the health record

Interior Health

COMPUTERIZED TOMOGRAPHY (CT) REQUISITION

Priority Level	
P1	An examination immediately necessary to diagnose and / or treat life-threatening disease. Such an examination will need to be done either stat or not later than the day of the request.
P2	An examination indicated within one week of a request to resolve a clinical management imperative.
P3	An examination indicated to investigate symptoms of potential importance.
P4	An examination indicated for long-range management or for prevention.
P5	Timed follow-up exam or specified procedure date recommended by Radiologist and / or clinician.

CT Prioritization Guidelines can be located on the BC Guidelines web page

CT Sites in Interior Health			
Cranbrook	East Kootenay Regional Hospital	13 – 24th Avenue N. Cranbrook, BC V1C 3H9	Phone: (250) 489-6482 Fax: (250) 426-5610
Kamloops	Royal Inland Hospital	311 Columbia Street Kamloops, BC V2C 2T1	Phone: (250) 314-2400 Fax: (250) 314-2326
Kelowna	Kelowna General Hospital	2268 Pandosy Street Kelowna, BC V1Y 1T2	Phone: (250) 862-4458 Fax: (250) 862-4357
Nelson	Kootenay Lake Hospital	3 View Street Nelson, BC V1L 2V1	Phone: (250) 354-2316 Fax: (250) 354-2328
Penticton	Penticton Regional Hospital	550 Carmi Avenue Penticton, BC V2A 3G6	Phone: (250) 492-9007 Fax: (250) 492-9094
Salmon Arm	Shuswap Lake General Hospital	601 – 10th Street Salmon Arm, BC V1E 4N6	Phone: (250) 833-3607 Fax: (250) 833-3628
Trail	Kootenay Boundary Regional Hospital	1200 Hospital Bench Trail, BC V1R 4M1	Phone: (250) 364-3416 Fax: (250) 364-3435
Vernon	Vernon Jubilee Hospital	2101 – 32 Street Vernon, BC V1T 5L2	Phone: (250) 558-1206 Fax: (250) 503-3721
Williams Lake	Cariboo Memorial Hospital	517 North 6th Avenue Williams Lake, BC V2G 2G8	Phone: (250) 302-3220 Fax: (250) 398-5892

ABBREVIATIONS:			
	CT – Computerized Tomography	**ICBC** – Insurance Cooperation of British Columbia	**MRN** - Medical Records Number
	DOB – Date of Birth	**IV** - Intravenous	**MSP** – Medical Services Plan
	F – Female	**M** - Male	**PNH** – Personal Health Number

Permanent part of the health record

Clear Form Print Form