CT COLONOGRAPHY (CTC) REQUISITION

Reset

Quinte Health Care

Department of Diagnostic Imaging
Tel. 613 969-7400 x2860 (BGH)
FAX 613-969-5561

ORDERING PHYSICIAN

Name:

Signature:

Copy to:

Date (dd/mm/yy):

PATIENT NAME:

DOB:

HCN:

HOME PHONE:

CELL PHONE:

ADDRESS:

INCOMPLETE AND ILLEGIBLE REQUISITIONS WILL BE RETURNED

Please include relevant imaging reports from outside centres. The table weight limit is 180 kg (400 lbs); heavier patients will not be booked. Diabetics on Metformin will be advised to discontinue it for 48 hours post IV contrast injection and have their renal function checked before restarting. Metformin can generally be restarted if a detected serum creatinine increase is < 25% of the patient's baseline.

PLEASE INFORM PATIENT THAT BOWEL PREPARATION IS CRITICAL AND THAT A RECTAL TUBE WILL BE USED FOR THIS EXAMINATION.

CLINICAL INDICATION: **Please note the objective of CTC is colonic cancer screening, colonic cancer staging, and completion of incomplete optical colonoscopies. PLEASE PROVIDE MOST RECENT OPTICAL COLONOSCOPY (OC) REPORT WITH THIS REQUISITION.**

Location: ❑Outpatient ❑Endoscopy ❑Inpatient _____(floor)

STUDY REQUESTED

- ❒ Screening Colonography
- ❒ Staging Colonography
  * GFR must be provided
- ❒ Completion of incomplete OC (if same day request, must call radiologist)

THE FOLLOWING MUST BE COMPLETED FOR ALL CTC REQUESTS

	YES	NO
Prior optical colonoscopy	☐	☐
Bowel surgery < 6 wks	☐	☐
Colonic biopsies < 6 wks	☐	☐
Deep	☐	☐
Superficial	☐	☐
Polypectomy < 6 wks	☐	☐
Active colitis/acute abdominal disease	☐	☐
Personal history of Colorectal Cancer	☐	☐

If Yes is chekced, dates must be provided:

THE FOLLOWING MUST BE COMPLETED FOR STAGING CTC Only

Patient weight in kg: _____

eGFR (mL/min): _____ Creatinine (µmol/L): _____

Note: Renal function indices must be ≤ 6 months

	YES	NO
Pregnant	◯	◯
Age over 70	◯	◯
Diabetes Mellitus	◯	◯
If yes, on Metformin?	◯	◯
Solitary kidney or Chronic renal disease	◯	◯
Sepsis or Volume contraction	◯	◯
Nephrotoxic medications	◯	◯
Hypertension and/or CAD	◯	◯
Previous chemotherapy	◯	◯
Organ transplant	◯	◯
Previous adverse contrast reaction	◯	◯

If yes, specify: _____

The Diagnostic Imaging department can suggest a prophylactic medication regimen by fax. The administration of such prophylaxis remains the responsibility of the referring physician.

OFFICE USE ONLY

Time Stamp:_____ Appointment date and time:_____ Site: ❑BGH ❑TMH

Technologist Notes:_____