

CT COLONOGRAPHY (CTC) REQUISITION



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 checked, 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	<input type="checkbox"/>	<input type="checkbox"/>
Age over 70	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
If yes, on Metformin?	<input type="checkbox"/>	<input type="checkbox"/>
Solitary kidney or Chronic renal disease	<input type="checkbox"/>	<input type="checkbox"/>
Sepsis or Volume contraction	<input type="checkbox"/>	<input type="checkbox"/>
Nephrotoxic medications	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension and/or CAD	<input type="checkbox"/>	<input type="checkbox"/>
Previous chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
Previous adverse contrast reaction	<input type="checkbox"/>	<input type="checkbox"/>

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: _____