



Tel: 416-323-7515 Fax: 416-323-6316

Tel: 416-340-3384 Fax: 416-340-4661

Patient Information

CARDIAC CT REQUISITION

| Medical Record No.: Health Card No.: | | Version Code: | | | | | |
|---|----------------------|---|---|------------|----------|----------------|--|
| Name: First Name | - Land Manager | DOB: | / | / | Sex: 🗖 N | Л Б | |
| | | | • | - | l Cl - · | | |
| | | Prov.: Postal Code: | | | | | |
| Home Tel.: Cell: | | Business Tel.: | | | | | |
| Mobility Status: | ☐ Stretcher ☐ Amb | oulance | Additional Info | o.: | | | |
| Billing Information: ☐ OHIP ☐ WSIB | ☐ Non Resident/ Othe | n Resident/ Other Claim/Insurance (with attachments): | | | | | |
| FOR PATIENT SAFETY THESE QUESTIONS MUST BE ANSWERED: | | | | | | | |
| Does any of the following apply? (check all that apply) | | | Clinical Information / Working Diagnosis: | | | | |
| YES NO ☐ Diabetes ☐ Renal Disease ☐ Pregnancy ☐ Treatment with Sildenafil or similar medication ☐ Status post CABG (Coronary Bypass Surgery) ☐ Status post Coronary Stent/PCI ☐ Heart Block ☐ Aortic Stenosis ☐ Any other Cardiac Surgery/ Intervention? If Yes, please specify: ☐ History of allergic reaction to IV contrast in last 10 years? If Yes, please describe (hives, cardiorespiratory REFERRING HEALTHCARE PROVIDER (REQUIRED) arrest, etc.): | | Check below for expedited Cardiology referral in the event that CCTA is positive: Cardiac Link Completed Tests and Associated Results Sites: Sinai Health System (SHS) University Health Network (UHN) Women's College Hospital (WCH) Other hospital/clinic (attach outside report(s)) Tests: REFERRING HEALTHCARE PROVIDER | | | | | |
| ☐ ☐ Does the patient require an interpreter? If Yes , what language? | F | Provider's First name | 2 | Last name | | Middle initial | |
| Weight: | C | City: Postal Code: | | | | | |
| Height: | Т | Telephone | e: | | | | |
| eGFR: | В | Billing #:_ | | | | | |
| | F | Fax: | | CPSO numbe | er: | | |

IMPORTANT INSTRUCTIONS for Referring Provider

If the patient has diabetes or impaired renal function, you must submit eGFR results done within 3 months of the CT appointment. For all Trans Aortic Valve Implantation (TAVI) requests, eGFR is mandatory. **Submit all surgical reports available.**

Provider's Signature: X _____ Date: ____ DD/MM/YYYY

INCOMPLETE/ILLEGIBLE REQUESTS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT.
FORM MUST BE COMPLETE, INCLUDING CLINICAL & SAFETY INFORMATION AND PROVIDER SIGNATURE

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