Trillium Health Partners
Better Together

# DIAGNOSTIC IMAGING REQUISITION
# CARDIAC CT SCAN

Mississauga Hospital Booking Line: 905-848-7580, x2481 Fax: 905-804-7926

**IMPORTANT NOTICE:** A booking will not be made for any CT examination unless all sections of this form are completed by the Referring Physician. If the test is being requested based on abnormalities found on an Imaging study performed outside of Trillium Health Partners, the relevant images/films/reports **MUST** accompany this requisition. The requisition **must be completed and signed by the physician**.

## PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address: _____

Height (metres):_____ Weight (kg):_____ (table capacity is 400lbs/185kg)

## REASON(S) FOR REFERRAL (check all that apply)

- ☐ Aortic Root / Aortic Valve / Thoracic Aorta
- ☐ Diagnosis of Coronary Artery Disease
  - ☐ Equivocal other non-invasive testing
  - ☐ Initial test to evaluate CAD
  - ☐ Follow-up of pre-existing CAD
- ☐ Evaluation of Bypass Graft Patency
- ☐ Other

### Clinical Information

## PRE BETA-BLOCKER SCREENING (complete for all patients)

Resting Heart Rate _____ Blood Pressure_____

| | Yes | No |
|---|---|---|
| Beta-blocker intolerant asthma | ☐ | ☐ |
| 2nd or 3rd degree heart block | ☐ | ☐ |
| Ventricular function less than 40% | ☐ | ☐ |
| Pulmonary arterial hypertension | ☐ | ☐ |
| **Patient Cleared for Beta-Blocker?** If "YES" patient cleared for beta-blocker, please provide the patient with the following prescription: • Metoprolol 50mg PO BID, beginning the night prior to the exam **OR** • Bisoprolol 2.5mg-5mg PO, the morning of the scan | ☐ | ☐ |
| **Beta-Blocker prescribed?** | ☐ | ☐ |

## PREVIOUS STUDIES

Please attach reports or provide site/date of exam:

Exercise ECG
☐ Not Done ☐ Low Risk ☐ High Risk ☐ Equivocal

Perfusion Imaging
☐ Not Done ☐ Low Risk ☐ High Risk ☐ Equivocal

Echo _____

CT/MR _____

## PRE NITROGLYCERIN SCREENING (complete for all patients)

| | Yes | No |
|---|---|---|
| History of cardiac tamponade, constrictive pericarditis, right ventricle infarction, hypertropic cardiomyopathy or pulmonary hypertension | ☐ | ☐ |
| Severe anemia – hemoglobin less than 80 g/L | ☐ | ☐ |
| Very severe aortic stenosis | ☐ | ☐ |
| The following medications will be held for 48 hours prior to the CT scan: • Sildenafil (Viagra®) • Tadalafil (Cialis®) • Vardenafil (Levitra®) • Avanafil (Stendra®) • Riociguat (Adempas®) | ☐ | ☐ |

## ALLERGIES

**Medication Allergies?** ☐ Yes ☐ No
If "YES" please state: _____

**Allergy to Beta-blockers?** ☐ Yes ☐ No

**Allergy to Nitroglycerin, nitrates, nitrites?** ☐ Yes ☐ No

**Iodinated Contrast Media Allergy?** ☐ Yes ☐ No
If "YES" please state contrast media type: _____
and reaction: _____

## ENHANCED EXAMS - Creatinine (complete for all patients)

| | Yes | No |
|---|---|---|
| Diabetes | ☐ | ☐ |
| High blood pressure requiring medication | ☐ | ☐ |
| Kidney issues, including single kidney | ☐ | ☐ |
| Is the patient 60 years of age or older? | ☐ | ☐ |

If "YES" to one or more of the above, a creatinine is required, **drawn within 6 months of the date the requisition is faxed.**

**Creatinine:** **Date:**

## REFERRING PROVIDER

Name of Referring Provider (Last Name, First Name- as listed in CPSO): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____