Health Sciences North
Horizon Santé-Nord

Cardiac CT Requisition

APPT Date:_____ Time:_____

Patient name:_____

Date of Birth :_____SH#_____

Address:_____

Health Card No:_____ Phone: _____

☐ **CT CORONARY ANGIOGRAM**
☐ **CT CALCIUM SCORING**
☐ **OTHER:_____**
_____

Ramsey Lake Health Centre/ Centre de santé du lac Ramsey
DIAGNOSTIC IMAGING/*VISUALISATION DIAGNOSTIQUE*
41 Ramsey Lake Rd., Sudbury ON P3E 5J1
www.hsnsudbury.ca

Fax Requisition, Relevant Reports and eGFR Results to Medical Imaging Bookings Fax 705-523-7286

Radiologist Protocol and signature:

OFFICE USE ONLY

Priority Rating: 1.☐ 2.☐ 3.☐ 4.☐

Clinical Information / Indication for Exam:

Symptoms: ☐ Typical chest pain ☐ Atypical chest pain ☐ Dyspnea ☐ Other_____ ☐ None

History of Allergy to IV Contrast: ☐ **YES** ☐ **NO If yes, type of reaction:**_____

Intolerance to BETA BLOCKERS: ☐ **YES** ☐ **NO** **On Chronic BETA BLOCKERS:** ☐ **YES** ☐ **NO**

Clinical Profile		**Risk for Contrast Nephropathy (Not required for Calcium Scoring only)**	
CABG	☐YES ☐NO Date:_____	Over 60 years of age	☐YES ☐NO
Coronary stent	☐YES ☐NO Date:_____	Diabetes	☐YES ☐NO
Prior Myocardial infarction	☐YES ☐NO	Hypertension requiring medication	☐YES ☐NO
Family HX premature CAD	☐YES ☐NO	Any other kidney problem (e.g. nephropathy, transplant, solitary kidney, surgery, cancer, dialysis)	☐YES ☐NO
Severe aortic stenosis	☐ YES ☐NO	**If YES to any of the above you MUST provide a current (within 3 months):**	
HOCM	☐YES ☐NO	**eGFR**_____	
Arrhythmia	☐YES ☐NO	**Test date:**_____ ☐ **pending**	

PHYSICIAN INSTRUCTIONS:

- If patient is not already on chronic beta blockers or Diltiazem/Verapamil, or have a Heart Rate < 60 bpm, then prescribe BISOPROLOL 5 mg to be taken for 3 days (inclusive of the CT scan day)
- If patient is prone to anxiety, please prescribe LORAZEPAM 1 mg 30 minutes prior to CT scan
  Patient will require someone to drive them home
- Instruct patient to abstain from VIAGRA ®, LEVITRA ®, or CIALIS®, for 48 hours prior to the test

Referring Physician	**Copies to:**
Phone# **Fax#**	
Physician Signature:	**Date:**

INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED