Health Sciences North
Horizon Santé-Nord

Cardiac CT Requisition

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

Patient name:_____

Date of Birth:_____ SH#_____

Address:_____

Health Card No: _____ Phone: _____

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:** _____

Heart Rate*: _____**bpm.** **Initials (mandatory)** _____
I acknowledge that this patient will receive the necessary premedication for heart rate control, as clinically indicated.

PLEASE NOTE: If the heart rate is **not documented AND initialed**, the requisition will be **returned to referring physician**.

BETA BLOCKER ADMINISTERED: ☐ **YES** ☐ **NO** **Dosage:** _____
If not, please mention reason: _____ **Any alternative given:** _____

***For CT Coronary Angiogram examinations**, **the referring physician is responsible for pre-scan heart rate control (<60 bpm)**, including prescribing and administering beta-blockers or alternative rate-control medication when appropriate. If the patient's HR remains >60 bpm, diagnostic quality may be limited, the scan may be prolonged or even cancelled.

Clinical Profile		**Risk for Contrast Nephropathy**	
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**	
Referring Physician		**Copies to:**	
Phone# **Fax#**			
Physician Signature:		**Date:**	

REVISED February, 2026