Shared health Soins communs Manitoba

CT REQUEST FORM

(clerical use only) **EPR Visit #:**

Sites referring to Central Intake fax to (204) 926 3650 or 1(866) 210 6119.
In all other cases fax directly to the nearest CT department.

Incomplete / illegible forms will be RETURNED

Failure to sign this request will delay patient care.
Required information is indicated with an "*" and must be completed or the request will be declined.

OUTPATIENT:

☐ 1st available (Winnipeg only)
☐ Willing to travel within Manitoba for 1st available appointment
☐ Preferred Site – Specify: _____

ED OUTPATIENT: follow up with ☐ ED Physician ☐ Primary Care Provider

INPATIENT / ED: ☐ Site: _____
Ward / Room #: _____ Phone: _____ _____

PATIENT INFORMATION

*Last Name / First Name:

*DOB: yyyy/mmm/dd *Sex _

MHSC: *PHIN:

Full Address:

Email Address:

*Daytime Phone: ( ) Mobile: ( )

Emergency Contact / Next of Kin: _____

Translator ☐ Language Required: _____

SCHEDULING

NB: Exam priority is based on the clinical judgement of the Radiologist and the clinical information provided

URGENCY: ☐ Emergent (contact radiologist directly) ☐ Urgent ☐ Elective ☐ Requested Exam Date: _____

Patient Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Geri Chair ☐ Stretcher ☐ Bed ☐ Lift Required

Isolation: ☐ No ☐ Yes, Specify: _____

Pregnant: ☐ No; Beta-HCG _____ Date _____ ☐ Yes LMP _____

Accurate Weight if over 250 lbs *Patient Weight: _____ (lbs)

EXAMINATION REQUEST

***Exam:**

Previous Relevant Exams:
Date: _____; Location: _____
Date: _____; Location: _____

***History:**

***Allergy to X-Ray dye?** - If known Specify: _____

***Renal Risk Stratification:** Known Kidney Disease: -
Prior or pending referral to specialist for renal function concerns: - Other Risk Factors: - Specify: _____

If yes to any above, please provide the most recent Creatinine result.

Serum Creatinine: _____ eGFR ____ Date _____ OR Point of Care (whole blood Creatinine): _____ Date

ORDERING CLINICIAN INFORMATION

_____ _____ _____ ( ) _____ ( ) _____
*Clinician Signature | *Clinician Name (print first & last) | Billing # | Fax # | *24hr Critical Results Contact #

_____ ( ) _____ _____ _____
Address | Phone # | *Date Ordered | Time Ordered (24hr)

_____ _____ ( ) _____ ( ) _____
Copy to: | Clinician Name | Location | Fax # | Phone #

FOR DEPARTMENT USE ONLY:

Approval Date: 17-APR-2025
SAP #377530
R250-10-115 V01