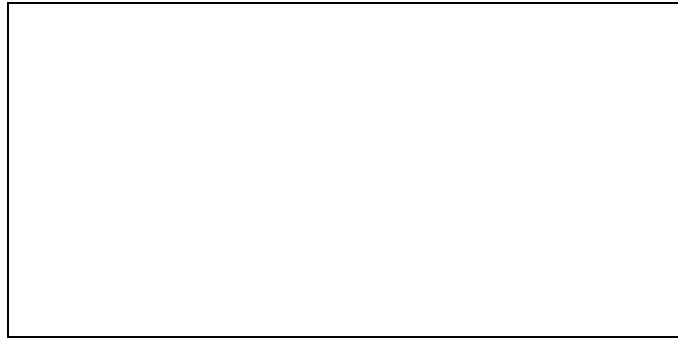




Diagnostic Imaging

COMPUTED TOMOGRAPHY (CT) CONSULTATION REQUEST



Guidelines: Regional Inpatient? Yes No

1. Physician to complete requisition. Incomplete requisitions will be returned.
2. Fax requisitions including Regional referrals to Diagnostic Imaging Central Intake **855-978-1862**
3. If there is relevant prior imaging from outside facilities, please provide reports with requisition.

CT Exam Requested – Please be specific / specify levels

Thorax Head Cervical Spine _____

Abdomen Sinus Thoracic Spine _____

Pelvis Neck Lumbar Spine _____

Renal Colic CT Angio _____

Other _____

CT Biopsy/Drainage

INR _____ Hemoglobin _____ Date Obtained _____

PTT _____ Platelets _____

Clinical Information

Cancer Staging and/or Diagnosis

Other

Relevant Previous Treatments/Studies	Date	Where
<input type="checkbox"/> Previous Chemotherapy	_____	_____
<input type="checkbox"/> Previous Radiotherapy	_____	_____
<input type="checkbox"/> MRI (Magnetic Resonance Imaging)	_____	_____
<input type="checkbox"/> CT (Computed Tomography)	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____
<input type="checkbox"/> X-Ray	_____	_____
<input type="checkbox"/> Nuclear Medicine	_____	_____
<input type="checkbox"/> Angiography	_____	_____

<p>Priority (P) Assessment</p> <p><input type="checkbox"/> 1 -Immediate - Emergent</p> <p><input type="checkbox"/> 2 -Within 48 Hours-Inpatient/Urgent</p> <p><input type="checkbox"/> 3 -Within 10 Days - Semi-Urgent</p> <p><input type="checkbox"/> 4 -Within 4 Weeks - Non-Urgent</p> <p><input type="checkbox"/> Greater than 4 Weeks - Date _____</p>	<p>Radiologist Use Only</p> <p><input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4</p>
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Patient Name _____

Last Name First Name

Date of Birth _____ Sex Male Female

Day/Month/Year

Health Card _____ Version Code _____

Address _____

City _____ Postal Code _____

Telephone Home (_____) _____

Business (_____) _____ Cell (_____) _____

Workplace Safety Insurance Board Claim Number _____

Other Insurance Claim Number _____

Risk factors for acute or chronic renal impairment and/or development of Contrast Induced Nephropathy

Diabetes Mellitus Yes No

• Is patient on **Metformin**? (see reverse) Yes No

Renal disease or solitary kidney Yes No

Sepsis or acute hypotension Yes No

Elderly (greater than 70 years of age) Yes No

Dehydration or volume contraction Yes No

Vascular disease (see reverse side) Yes No

Nephrotoxic drugs (see reverse side) Yes No

Previous chemotherapy Yes No

Human immunodeficiency syndrome or acquired Immunodeficiency syndrome Yes No

Collagen Vascular Disease (see reverse side) Yes No

Organ transplant Yes No

If any risk factors are present, an eGFR evaluation must be performed prior to iodinated contrast exam.

eGFR (estimated Glomerular Filtration Rate) _____

Date of blood test _____

(Please specify if pending)

Is patient on dialysis? Yes No

(See Thunder Bay Regional Health Sciences Centre Guidelines on reverse side for Screening and Prevention of Contrast Nephropathy).

Allergies

Allergy to IV contrast media containing iodine? Yes No

• Will patient be pre-medicated? Yes No

Allergy to medications? Yes No

• Please list _____

Other severe allergies _____

(See protocol on reverse side).

Referring Physician _____

Referring Site or Clinic _____

Copy Report to _____

Physician's Signature * _____

Date _____

INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.

GUIDELINES FOR SCREENING AND PREVENTION OF CONTRAST INDUCED NEPHROPATHY

(Adapted from the Canadian Association of Radiologists - Webpage: <http://www.car.ca>)

CONTRAST INDUCED NEPHROPATHY (CIN) is an acute deterioration of renal function that occurs 24 to 48 hours following injection of iodinated contrast media for CT scans, angiograms and venograms. The most important risk factor is pre-existing renal impairment, particularly Diabetic Nephropathy.

FOR PATIENTS WITH 1 OR MORE RISK FACTORS for impaired renal function, an eGFR (estimated Glomerular Filtration Rate) will be required prior to an intravenous contrast CT examination. For outpatient tests, the eGFR must be acquired within **1 month** of CT Scan; within **48 hours** for in-patients. In emergent situations, eGFR may be waived – proceed with intravascular volume expansion.

ALL PATIENTS with eGFR 30-45 ml/min/1.73 m ²	PATIENTS with eGFR less than 30 ml/min/1.73 m ²
Ensure adequate Intravenous saline hydration (see below) Intravenous Hydration for Contrast Study: <ul style="list-style-type: none"> • For inpatients – intravenous saline 1 ml/kg/h for twelve (12) hours prior to procedure and twelve (12) hours post procedure. • For fluid loading for same day scan – intravenous saline 1-2 ml/kg/hr three (3) – six (6) hours prior to procedure and six (6) hours post procedure. • For rapid volume expansion, consider – sodium bicarbonate 3 amps (150 meq) in 850 ml D5W at 3 ml/kg/h for one (1) hour before contrast administration and at 1 ml/kg/h for six (6) hours after contrast administration. 	Consider alternate imaging modalities. If a contrast enhanced CT scan is considered diagnostically necessary, hydrate patient. Consider post scan dialysis.
Follow-up Renal Function test at 2 days	Follow-up Renal Function tests at 2 and 5 days
Hold nephrotoxic drugs 48 hours prior to contrast when possible. (Nephrotoxic Drugs include: loop diuretics, amphotericin B, aminoglycosides, vancomycin, non-steroidal anti-inflammatory drugs, cancer and immune suppressant chemotherapy) Vascular disease: hypertension, congestive heart disease, cardiac or peripheral vascular disease Collagen Vascular Disease: a heterogeneous group of autoimmune disorders of unknown etiology. They include systemic lupus erythematosus (SLE), rheumatoid arthritis (RA), progressive systemic sclerosis (PSS), scleroderma (SD), dermatomyositis (DM)/polymyositis (PM), ankylosing spondylitis (AS), Sjögren syndrome (SS), and mixed connective-tissue disease (MCTD).	
Hold diuretics especially Furosemide at least 24 hours prior to contrast, when possible.	
Avoid repeat contrast studies for 3-10 days, if possible	

PRESCRIPTION OF CONTRAST:

If the eGFR greater than 45 mL/min/1.73 m², unless otherwise requested, contrast will be prescribed at the radiologists' discretion.

If the eGFR is between 30-45 mL/min/1.73 m², unless otherwise requested, contrast will be prescribed at the radiologists' discretion.
Please ensure to follow the above recommendations.

If the eGFR is less than 30 mL/min/1.73 m², contrast will not be prescribed unless the case is discussed with the radiologist.

If the patient has a risk for contrast nephropathy and no eGFR is provided, the study will either be performed without contrast or postponed, if contrast is considered necessary for diagnostic purposes. If the eGFR is pending, upon receiving the eGFR value, the referring physician will be contacted by facsimile to confirm.

EVALUATION OF FOLLOW-UP RENAL FUNCTION TESTS IS THE RESPONSIBILITY OF THE ORDERING PHYSICIAN.

METFORMIN PROTOCOL:

Hold Metformin on day of contrast study and for 48 hours post contrast. Restart Metformin if repeat renal function test demonstrates stability of renal function (less than 25 per cent increase compared to baseline function).

CONTRAST MEDIA ALLERGY PREMEDICATION (See Guidelines: <http://www.car.ca>)

- Prednisone 50 milligrams orally, thirteen (13), seven (7) and one (1) hour prior to study
- Diphenhydramine (Benadryl) 50 milligrams orally one (1) hour prior to study

BREASTFEEDING PATIENTS

It is recommended that patients who have had an injection of contrast media should stop breastfeeding for 24 hours after their CT scan. Patients should pump and discard breast milk during these 24 hours. Patients should consider pumping and saving breast milk prior to the scan.

Abbreviation Legend: INR – International Normalized Ratio
m² - metre squared

PTT – Partial Thromboplastin Time
kg – kilogram

ml – milliliter
h – hour

min – minute
meq - milliequivalent