Computed Tomography (CT)

Important Information Regarding a CT Scan

Risk Factors

Date: ______________________________

Dear Dr. ______________________________

A referral was received for: ____

The radiologist has recommended that this CT be performed using Intravenous (IV) contrast media to enhance sensitivity and assist with optimal interpretation of the scan.

The results of your patient's estimated glomerular filtration rate (eGFR) in combination with the risk factors noted on the CT requisition put your patient at a higher risk for contrast induced side effects. As a result of this the radiologist has recommended:

☐ **IV Hydration** Radiologist's initials ___________

If you wish to proceed with IV contrast media the **CT department will arrange a bed in Ambulatory Care on your behalf.** As such, you must be available for immediate consult in the event there are complications during IV hydration.

The Radiologist will not order hydration and it is your responsibility to order the type of solution, rate and amount you want. There are recommendations on the reverse side of the CT requisition.

Please complete this form including orders and fax back to CT 684-5853.

It is important that you order follow up blood work (eGFR) to be done 48 hours after the CT scan is complete.

If you are concerned about the risk associated with the use of contrast media for this patient, the radiologist will reassess the CT request and make a decision whether to proceed with a non contrast examination or to recommend an alternate test.

PLEASE COMPLETE & FAX TO: 684-5853

I would like to:

☐ Proceed with IV contrast CT and IV hydration as recommended by Radiologist.
- ☐ Pre: Solution: _________ Rate: _________ Amount: _________
- ☐ Post: Solution: _________ Rate: _________ Amount: _________

☐ Proceed with IV contrast CT but WITHOUT IV hydration and assume full responsibility for coordinating & reviewing post CT blood work. (Note – the referring MD must provide the patient with a laboratory requisition)

☐ Proceed with CT but WITHOUT IV CONTRAST and NO IV HYDRATION.

Ordering Physicians Name: ______________________ Signature: ______________________

Contact Number: ____________________ Date: ______________________