



## IMAGING SERVICES OUT-PATIENT BOOKING

(Check Appropriate Box)

BDN  CAR  CT  ECH  IVR  MRI  NUC  | RAD  | ULT

APPOINTMENT																											
DATE:	M T W T H F S S	TIME:	BOOKED BY:																								
<b>A FEE OF \$50.00 WILL BE CHARGED IF A MINIMUM OF 24 HOURS NOTICE IS NOT GIVEN FOR MISSED OR CANCELLED APPOINTMENTS</b>																											
REQUIRED PATIENT INFORMATION																											
PATIENT'S SURNAME:		GIVEN NAMES:																									
BIRTH DATE:	SEX M <input type="checkbox"/> F <input type="checkbox"/>	MAIDEN NAME:																									
YY      MM      DD																											
PHN and/or MRN:																											
ADDITIONAL PATIENT INFORMATION																											
ADDRESS		Phone No.(H)																									
		Phone No.(W)																									
Postal Code:		Financial Class    MSP <input type="checkbox"/> WCB <input type="checkbox"/> Self Pay <input type="checkbox"/> Other <input type="checkbox"/>																									
FOR RAD DAY CARE PATIENTS    DCR <input type="checkbox"/> DCO <input type="checkbox"/>		WCB #:																									
CLINICAL INFORMATION																											
Procedure/Type of Exam		Previous X-rays																									
Tentative Diagnosis																											
History and Clinical Diagnosis including date onset of symptoms																											
Ordering Doctor:		MSP#	Signature:																								
Copy of Report to: (1)		(2)																									
Previous Examination results: X-rays C.T. Ultrasound Nuclear Medicine ECG		Area for CT: Head      Chest      Abdomen      Pelvis      Spine      Other																									
Previous back surgery    Yes <input type="checkbox"/> No <input type="checkbox"/> Allergies    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes (specify) _____ Diabetic    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, is the patient taking Gluophage (Metformin)    Yes <input type="checkbox"/> No <input type="checkbox"/>		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2"></th> <th style="width: 10%;">Without</th> <th style="width: 10%;">With</th> </tr> </thead> <tbody> <tr> <td style="width: 15%;">Telebrix</td> <td style="width: 75%;"></td> <td></td> <td></td> </tr> <tr> <td>Water</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Intravenous Contrast</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Slice Width</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Priority</td> <td></td> <td>Approximate Time</td> <td></td> </tr> </tbody> </table>				Without	With	Telebrix				Water				Intravenous Contrast				Slice Width				Priority		Approximate Time	
		Without	With																								
Telebrix																											
Water																											
Intravenous Contrast																											
Slice Width																											
Priority		Approximate Time																									

## **Guidelines for Ordering CT Scan in Adults with Acute Head Injury**

### **Absolute indications:**

- 1) GCS < 15 in the absence of intoxicant
- 2) Deteriorating level of consciousness
- 3) Depressed skull fracture

### **Consider CT scan in the following situation:**

- 1) **GCS 15 - At the discretion of the physician. Risk factors to consider:**
  - Abnormal examination suggesting a focal lesion
  - Skull fracture in children
  - Extremes of age
  - Mechanism of injury such as pedestrian struck
  - Bleeding diathesis
  - Severe persistent symptoms such as headache or vomiting
  - Prolonged loss of consciousness
  - Multiple trauma with head injury requiring general anesthetic
- 2) **GCS < 15 with intoxicant - Consider observation initially. CT scan at discretion of physician if:**
  - Patient has other risk factors
  - Level of consciousness does not improve or is inconsistent with blood alcohol level