



**CT REFERRAL FORM**

Patient's Name: \_\_\_\_\_  
 Sex: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 Referring Doctor: \_\_\_\_\_  
 Hospital: \_\_\_\_\_ Ward: \_\_\_\_\_

Date: \_\_\_\_\_

**MEDICAL HISTORY** (Please ✓ the appropriate)

- Metallic Implant
- Diabetes Mellitus
- Glaucoma
- Hypertension
- Arrhythmia
- LMP \_\_\_\_\_
- Previous Surgery \_\_\_\_\_

**ALLERGY HISTORY** (Please ✓ the appropriate)

- Asthma
- Sea Food Allergy
- Drug Allergy \_\_\_\_\_
- Previous Reaction to Contrast
- Currently on Metformin / Glucophage

*To reduce the remote theoretical risk of contrast nephropathy, Metformin should be discontinued at the time, or prior to the intravascular contrast examination and withheld for the subsequent 48 hours, unless referring clinicians have clinical reasons for advising otherwise.*

HEAD & NECK	BODY	CT ANGIOGRAM
<ul style="list-style-type: none"> <li><input type="checkbox"/> Brain</li> <li><input type="checkbox"/> Orbits</li> <li><input type="checkbox"/> Facial Bone</li> <li><input type="checkbox"/> Paranasal Sinuses</li> <li><input type="checkbox"/> IAM / Petrous Bone</li> <li>_____</li> <li><input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Nasopharynx</li> <li><input type="checkbox"/> Parotid / Submandibular Glands</li> <li>_____</li> <li><input type="checkbox"/> Dentscan</li> <li><input type="checkbox"/> CT Perfusion Study</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Thorax</li> <li><input type="checkbox"/> Upper Abdomen <i>(from diaphragm to iliac crest)</i></li> <li><input type="checkbox"/> Pelvis <i>(from iliac crest to pubic symphysis including appendix)</i></li> <li><input type="checkbox"/> Whole Abdomen</li> <li>_____</li> <li><input type="checkbox"/> Low Dose Lung Cancer Screening <i>(plain scan)</i></li> <li><input type="checkbox"/> High Resolution Lung <i>(HRCT)</i></li> <li><input type="checkbox"/> CT Bronchoscopy</li> <li><input type="checkbox"/> CT Colonoscopy</li> <li><input type="checkbox"/> CT Urogram <i>(from kidneys to pubic symphysis)</i></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Circle of Willis</li> <li><input type="checkbox"/> Carotid and Vertebral Arteries</li> <li><input type="checkbox"/> Pulmonary Artery</li> <li><input type="checkbox"/> Thoracic Aorta</li> <li><input type="checkbox"/> Abdominal Aorta</li> <li><input type="checkbox"/> Coeliac, Hepatic and Mesenteric Arteries</li> <li><input type="checkbox"/> Upper / Lower Limbs CTA</li> <li><input type="checkbox"/> Hypertension Package <i>(kidneys, adrenals and renal artery)</i></li> <li>_____</li> <li><input type="checkbox"/> Calcium (Ca<sup>++</sup>) Score</li> <li><input type="checkbox"/> Ca<sup>++</sup> Score + Coronary CTA</li> <li><input type="checkbox"/> Ca<sup>++</sup> Score + Coronary CTA Cardiac MR Full Package</li> </ul>
<b>OTHER</b> (Please specify the body region)		

**Intravenous Contrast**     Yes     No     Optional (To be decided by Radiologist)

Clinical Information -

Signature \_\_\_\_\_