Central Alberta Medical Imaging Services

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NUCLEAR MEDICINE / CT REQUEST FORM

Appt Date/Time _____

Patient Information

Name _____ M ☐ F ☐ Other ☐

Address _____ DOB (D/M/Y) _____

City _____ A.H.C.# _____

Province _____ Postal Code _____ WCB Claim # _____

Phone Home _____ Alt _____ Date of Injury (D/M/Y) _____

Clinical Information (Required) _____

_____

_____

_____

_____

Post SPECT/CT

☐ (to guide facet injections)
Based on the SPECT/CT findings, please proceed with appropriate injections.

☐ Bone Scan
☐ HIDA (Hepatobiliary) +GBEF
☐ Parathyroid
☐ MUGA

Computed Tomography (CT)

(Private Pay Uninsured Service)

Head / Neck / Chest
☐ Enhanced Head
☐ Unenhanced Head
☐ Orbits
☐ Paranasal Sinuses
☐ Temporal Bones
☐ Bony Pelvis / Hips
☐ Non-Contrast Chest

Spine Extremity
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ SI Joints
☐ Extremity _____
_____

CT Exams

Complete Checklist Below

Previous allergy to Xray Contrast (Dye)	Y ☐ N ☐
Previous allergy to CT Contrast	Y ☐ N ☐
Pregnant	Y ☐ N ☐
Breastfeeding	Y ☐ N ☐
Renal Failure	Y ☐ N ☐

NOTE: CT patients with renal disease or waiting to see a kidney specialist must have a serum creatinine within the last 90 days.

Referring Physician

Stat Report ☐

Name _____ PRAC ID _____

Address _____ Signature _____

_____ CC _____

Phone _____ Fax _____ _____ Fax _____