timelymedical
alternatives

REQUEST FOR A **COMPUTED TOMOGRAPHY (CT) SCAN**

Timely Medical Alternatives Inc.
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MR | MRS. | MISS | MS

SURNAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

ADDRESS: _____ **CITY:** _____ **PROVINCE:** _____

POSTAL CODE: _____ **PHONE** (work)**:** _____ **PHONE** (Home)**:** _____

DATE OF BIRTH: DD / MM / YY **AGE:** _____ **SEX:** _____

APPOINTMENT DATE: _____ **TIME:** _____

RELEVANT PREVIOUS FILMS

XRAY:
DATE: _____
LOCATION: _____

ULTRASOUND:
DATE: _____
LOCATION: _____

CT SCAN:
DATE: _____
LOCATION: _____

MRI SCAN:
DATE: _____
LOCATION: _____

RENAL FUNCTION ABNORMAL?
NORMAL / ABNORMAL
CREATININE: _____

DIABETES MELLITIUS:
YES / NO

ALLERGY/ASTHMA/HAY FEVER:
(SPECIFY) _____

EXAM REQUESTED:

TENTATIVE DIAGNOSIS:

RELEVANT HISTORY/REASON FOR EXAM (Include any medications)

DEPARTMENTAL USE 1 2 3
APPOINTMENT TIME: _____

TECHNOLOGIST'S COMMENTS:

PROTOCAL: _____
PRELIMS: _____
PREGNANCY: _____
LEAD USED: _____

TECH	TECH

INCOMPLETE REQUESTS WILL BE RETURNED

_____ M.D. _____ _____
SIGNATURE OF AUTHORIZING PHYSICIAN PLEASE PRINT NAME PRAC. NO.

PHONE NUMBER: _____
FAX NUMBER: _____

ADDITIONAL COPY OF REPORT TO: _____
FAX NUMBER: _____