

For appointments
please call
CENTRAL BOOKING
780-669-2222
Toll Free: 1-866-771-9446
Fax: 780-930-1593
*no appointment needed
for general x-ray



Meadowlark CT
200 Meadowlark Health Centre
156 Street - 89 Ave
Edmonton, AB T5R 5W9
Phone: 780-444-5652
Fax: 780-444-5642
FREE PARKING

PLEASE FILL OUT COMPLETELY - an incomplete requisition may delay scheduling

NAME: _____ APPT. DATE: _____ TIME: _____

ADDRESS: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK: _____ CELL: _____ DATE OF BIRTH: _____

MALE FEMALE Date of LMP: _____ DD/MM/YY WEIGHT: _____ PHN: _____

THIRD PARTY PAYMENT: _____ WCB CLAIM NUMBER: _____ DATE OF ACCIDENT: _____ DD/MM/YY

Private facility payment is due on completion of CT Scan, except for Third Party Patients

Please keep your appointment. If you don't cancel 24 hours prior to exam, you may be charged a \$25.00 fee. Remember that others with healthcare needs could use your appointment time.

CT EXAMINATION(S) REQUESTED

Head & Neck:	Spine:	Body:	Screening: (no IV contrast)
<input type="checkbox"/> Routine Head	<input type="checkbox"/> Cervical (Levels _____)	<input type="checkbox"/> Coronary CT Angiography	<input type="checkbox"/> Virtual Colonoscopy (CT Colonography)
<input type="checkbox"/> Orbits	<input type="checkbox"/> Thoracic (Levels _____)	<input type="checkbox"/> Chest	<input type="checkbox"/> Coronary CT Angiography
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Lumbar (Levels _____)	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Coronary CT Calcium Score
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> SI Joints	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Whole Body CT Screen (Chest, Abd, Pelvis)
<input type="checkbox"/> Paranasal Sinuses	Other:	<input type="checkbox"/> Extremity _____	
<input type="checkbox"/> Temporal Bones	<input type="checkbox"/> Specify _____		

PHYSICAL FINDINGS, PROVISIONAL DIAGNOSIS & RELEVANT HISTORY:

PREVIOUS RELEVANT X-RAYS, ULTRASOUND, CT, MRI No Yes Where? _____ When? _____

REFERRING PHYSICIAN'S NAME: _____ REFERRING PHYSICIAN'S SIGNATURE: _____

ADDRESS: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

COPY TO: _____ PHONE: _____ FAX: _____

PLEASE COMPLETE THE FOLLOWING CHECKLISTS:

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Breast Feeding
<input type="checkbox"/>	<input type="checkbox"/>	Previous allergies due to X-ray dye (Premedication regimen available on request)
<input type="checkbox"/>	<input type="checkbox"/>	Renal failure / Myeloma / Pheochromocytoma
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Taking Glucophage (Metformin)

Note: Patients with any of the following must have a serum creatinine WITHIN THE LAST 90 DAYS.

- Over 70 years of age
- Diabetic
- Cardiac Disease
- Renal Disease
- Hypertension