Rutland Regional Medical Center
160 Allen Street, Rutland, VT 05701
Diagnostic Imaging / CT Department, Fax 802-747-6200
Utilization Dept / Phone 747-6220, Fax: 802-747-3950

(Patient Sticker)

Room number/bed____________________
Vent Y or N
Precautions Y or N

CT REFERRAL FORM

Name:_______________________________________ DOB:_____________________ Patient's weight:___________

Date CT Scheduled:______________MRN #:_______________Ordering Physician&Primary:______________________________

Reason for Exam:____

Does patient have difficulty laying flat on back? ____

TYPE OF CT DESIRED:

_____BRAIN w/o or w IV Contrast **5011 or 5010**

_____ORBITS w IV Contrast **5060**

_____FACIAL BONES/SINUSES **5097**

_____PETROUS BONES/MASTOIDS **5093**

_____NECK (SOFT TISSUE) w IV Contrast **5080**

_____CHEST w IV Contrast **5020**

_____PE Study w IV Contrast (CT CHEST) **5020**

_____KIDNEY/URETERS (ABD WO & PELVIS WO) **5031 & 5041**

_____ABDOMEN w IV Contrast **5030**

_____PELVIS w IV Contrast **5040**

_____HEMATURIA PROTOCOL- **5032, 5042, & 1505** (ABD WO/W, PELVIS WO/W, & KUB)

_____CERVICAL SPINE **5089**

_____LUMBAR SPINE **5064**

_____PELVIS/HIPS **5041**

_____EXTREMITY UPPER ___________

_____EXTREMITY LOWER ___________

_____CTA w IV Contrast; SPECIFY AREA___________

_____OTHER; Specify________________________

Allergy history: ____

Is patient allergic to the x-ray dye? YES ☐ NO ☐

If YES, please explain: ____

____

Pregnant? YES ☐ NO ☐ Diabetic? YES ☐ NO ☐

✶ Glucophage, Metformin, Glucovance, Metaglip, Avandamet? YES ☐ NO ☐

Last dose? ____

☐ Instructions given per Metformin policy ☐ Patient verbalizes understanding

Prior pertinent surgery ____

____

IF PATIENT IS HAVING AN IV CONTRAST EXAM:

BUN__________ CREATININE____________ DATE______________

Required for diabetics and patients over 60 yrs of age.

FOR DI STAFF USE ONLY

DRINKS: **Gastro** ☐ **Ba Sulfate** ☐

TIME/INITIALS: ___________ ___________ ___________ ___________

Date/Time IV start: _____________________________________

Device/Location: _______________________________________

Pre-medication: ____

Signature/Initials: ______________________________________

Amount/Type of contrast: _______________________________

Date/Time IV D/C: ______________________________________

Site: Redness? YES ☐ NO ☐ Edema? YES ☐ NO ☐

Signature/Initials: ______________________________________

✶ **If patient is being scheduled for an exam with IV contrast and is taking Glucophage, Metformin, Glucovance, Metaglip, or Avandamet, patient must hold medication for at least 48 hours post exam. Patient will require a stable BUN and Creatinine prior to restarting the above medications.**

OTHER ORDER CONSIDERATIONS:____

FOR UM USE ONLY:

PREAUTH NEEDED? YES ☐ NO ☐ PCP_____________________________ CALLED BY UM________________ WHO'LL SEEK PA? PCP ☐ UM ☐

INSURANCE CO___________________________________ POLICY #_________________________________ PREAUTH #_______________________