BROWN - DARRELL CLINIC

129 SOUTH ROAD
SMITHS PARISH HS01
BERMUDA

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CT SCAN REFERRAL

Patient Name: ______________________ Date: DD / MM / YY

Patient Address: ______________________

Date of Birth: DD / MM / YY Phone Cell: ________ Work: ________ Home: ________

Email: ______________________

Appointment Date: DD / MM / YY Time: ________ Lahey Clinic # ________

Insurance Company: ________ Policy Number: ________ Certificate Number: ________

BODY

- ☐ UPPER ABDOMEN
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ CHEST
- ☐ OTHER ________

MUSCULOSKELETAL

- ☐ UPPER EXTREMITY
- ☐ LOWER EXTREMITY
- ☐ RIGHT
- ☐ LEFT
- ☐ BILATERAL
- ☐ PELVIS
- ☐ OTHER ________

CARDIOVASCULAR

- ☐ CARDIAC
- ☐ CALCIUM SCORE
- ☐ P.E. PROTOCOL
- ☐ RENAL
- ☐ AORTA
- ☐ RUN-OFF
- ☐ CAROTID
- ☐ BRAIN
- ☐ OTHER ________

NEURO

- ☐ BRAIN
- ☐ SINUS
- ☐ FACIAL BONES
- ☐ ORBITS
- ☐ TEMPORAL BONES
- ☐ SOFT TISSUE NECK
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ OTHER ________

IS THIS PATIENT SENSITIVE TO IV CONTRAST MEDIA THAT CONTAIN IODINE? ◯ **YES** ◯ **NO**

IF YES, referring physician should prescribe the following:

13 Hours before exam, Prednisone 50 mg orally.
7 Hours before exam, Prednisone 50 mg orally.

Prednisone 50 mg orally WITH Diphenhydramine (Benadryl) 50 mg orally.
To be taken at Brown-Darrell 1 hour before exam

IS THIS PATIENT ON DIALYSIS ◯ **YES** ◯ **NO**

IF YES, patient should have dialysis within 24 hrs after infusion of contrast

BUN________ Creatinine________ Date________

(No Blood Tests necessary for musculoskeletal ct)

Symptoms/Reason(s) for CT: ______________________

______________________ ICD CODE: ________

Name of MD ________ Phone (o) ________ (c) ________

Signature ________ Email ________