BROWN - DARRELL CLINIC

129 SOUTH ROAD
SMITH'S PARISH HS-01
BERMUDA

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CT SCAN REFERRAL

Patient Name _____ Date _____

Patient Address _____

DOB (DD/MM/YY) _____ Phone (c) _____ (w) _____ (h) _____

Allergies _____ Gender: __ Male __ Female

APPT. DATE: _____ TIME: _____ LAHEY CLINIC # _____

BODY

- ☐ UPPER ABDOMEN
- ☐ ABDOMEN
- ☐ PELVIS
- ☐ CHEST
- ☐ OTHER _____

MUSCULOSKELETAL

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

NEURO

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

CARDIOVASCULAR

- ☐ CARDIAC
- ☐ P.E. PROTOCOL
- ☐ RENAL
- ☐ AORTA
- ☐ RUN-OFF
- ☐ CAROTID
- ☐ BRAIN
- ☐ 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 _____

_____

NAME OF MD _____ Phone (o) _____ (c) _____

SIGNATURE _____ EMAIL _____