CT Angiography Imaging Request Form

Patient Information

Full Name

Date of Birth

Gender Select

Patient ID / MRN

Contact Number

Allergies

Weight (kg)

Clinical Information

Clinical Indication

Relevant History / Previous Imaging

Requested Scan

Type of Angiography

- [ ] Head & Neck
- [ ] Chest
- [ ] Abdomen
- [ ] Pelvis
- [ ] Peripheral
- [ ] Other

If 'Other', specify

Specific Vessels/Area to be Assessed (if any)

Contrast Usage

Creatinine Level (if available)

Date of Test

eGFR (if available)

Any Known Contrast Allergy? Select

Is Patient Diabetic? Select

Requesting Physician

Name

Department

Contact Number

Physician's Signature

Date
