Renal CT Scan Radiology Request

Patient Information

Full Name

Date of Birth

Gender

Patient ID / MRN

Contact Number

Clinical Details

Clinical Indication / Relevant History

Renal Function (Creatinine/EGFR)

Allergies (Contrast agent / Others)

Type of CT Scan

Requested Exam e.g., Kidneys, Ureters, Bla

With Contrast? Yes / No

Special Instructions

Referring Physician

Name

Contact Number

Signature

Date

Physician's Signature

Date