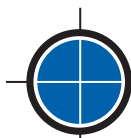


# PLEASE USE THIS FORM FOR CT CALCIUM SCORING ONLY



**ONTARIO MRI & CT**

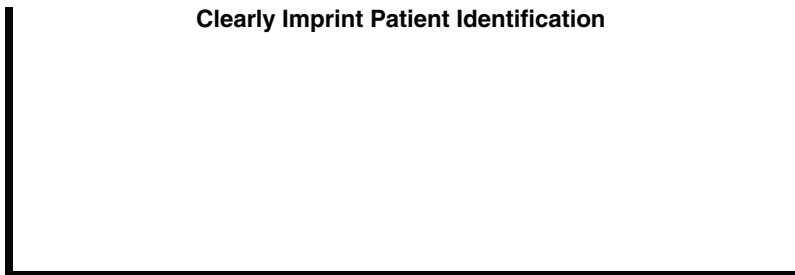
**Toronto General Hospital**

585 University Avenue, Toronto, ON M5G 2N2

Phone 905-275-4664 1-888-826-7836

Fax 905-275-4774 1-866-233-4477

Clearly Imprint Patient Identification



Modality	Floor or Location												
CT (Computed Tomography)	Medical Imaging Main Reception, located on the first floor of the West Bldg. (or new clinical services bldg.)												
Patient's Name: _____													
Toronto General Hospital Identification Number: _____	Ontario Health Insurance Card Number: _____ Version: _____												
Date of Birth (YYYY - MM - DD) _____	Full Address _____ _____ _____												
Telephone (Home) _____													
Telephone (Work) _____													
Third Party Payer: _____													
Contact Person: _____													
Address: _____													
City: _____ Postal Code: _____													
Telephone: (____) _____ Fax: (____) _____													
<b>The following MUST be completed by the Referring Physician:</b>													
Exam Requested: _____	<table style="width: 100%; border: none;"> <tr> <td colspan="2" style="text-align: center;"><b>Medical History</b></td> </tr> <tr> <td style="width: 50%;"><b>Personal</b></td> <td style="width: 50%;"><b>Family</b></td> </tr> <tr> <td>Hypertension    <input type="checkbox"/> N   <input type="checkbox"/> Y</td> <td>Heart Disease    <input type="checkbox"/> N   <input type="checkbox"/> Y</td> </tr> <tr> <td>Hyperlipidemia    <input type="checkbox"/> N   <input type="checkbox"/> Y</td> <td>Hyperlipidemia    <input type="checkbox"/> N   <input type="checkbox"/> Y</td> </tr> <tr> <td>Diabetes    <input type="checkbox"/> N   <input type="checkbox"/> Y</td> <td>Diabetes    <input type="checkbox"/> N   <input type="checkbox"/> Y</td> </tr> <tr> <td>Current Smoker    <input type="checkbox"/> N   <input type="checkbox"/> Y</td> <td></td> </tr> </table>	<b>Medical History</b>		<b>Personal</b>	<b>Family</b>	Hypertension <input type="checkbox"/> N <input type="checkbox"/> Y	Heart Disease <input type="checkbox"/> N <input type="checkbox"/> Y	Hyperlipidemia <input type="checkbox"/> N <input type="checkbox"/> Y	Hyperlipidemia <input type="checkbox"/> N <input type="checkbox"/> Y	Diabetes <input type="checkbox"/> N <input type="checkbox"/> Y	Diabetes <input type="checkbox"/> N <input type="checkbox"/> Y	Current Smoker <input type="checkbox"/> N <input type="checkbox"/> Y	
<b>Medical History</b>													
<b>Personal</b>	<b>Family</b>												
Hypertension <input type="checkbox"/> N <input type="checkbox"/> Y	Heart Disease <input type="checkbox"/> N <input type="checkbox"/> Y												
Hyperlipidemia <input type="checkbox"/> N <input type="checkbox"/> Y	Hyperlipidemia <input type="checkbox"/> N <input type="checkbox"/> Y												
Diabetes <input type="checkbox"/> N <input type="checkbox"/> Y	Diabetes <input type="checkbox"/> N <input type="checkbox"/> Y												
Current Smoker <input type="checkbox"/> N <input type="checkbox"/> Y													
Brief Clinical History: _____													
Doctor's Telephone: _____	Doctor's Name and Initials (Print): _____												
Doctor's FAX _____	Doctor's Signature _____												
MD													
<b>Medical Imaging Use Only → Appointment Date (YYYY MM DD):</b>													
<b>Appointment Time (24h clock):</b>													