Lilongwe Institute of Orthopaedics and Neurosurgery
Department of Radiology

CT REQUEST FORM

	Date of Requisition	
	Surname	First name
Patient name		
Date Of Birth		
Sex		
Weight		kg

Referral ward/department	
Referring doctor (PLEASE PRINT)	
Phone number	

Requested examination		
Requested time of examination	☐ Routine	☐ Urgent

Clinical findings and short history:

Provisional diagnosis:

Previously known severe contrast media reaction:	Yes ☐	No ☐
Known kidney failure	Yes ☐	No ☐
Biochemistry results:		
Creatinine:		mg/dl
Urea:		mg/dl

Signature: ____

For the radiology department:

Protocol:

i.v. CM (+ /- type, concentration, volume):

Oral CM (+ /- type, concentration, volume):

Initials: