KAPI'OLANI
MEDICAL CENTER
FOR WOMEN & CHILDREN

An affiliate of Hawaii Pacific Health

1319 Punahou St., Honolulu, HI 96826

CT OUTPATIENT REQUEST

Scheduling: 808 535-7000
Phone: 808 983-8630
Fax: 808 983-8133

Patient Name _____

Date of Birth _____ Home Phone _____ Work Phone _____

Date Scheduled _____ Registration Time _____ Procedure Time _____

Date/Location of previous CT scan

Allergies	☐ yes	☐ no	If yes, list medications: _____
Asthma	☐ yes	☐ no	If yes, was allergy prep given? ☐ yes ☐ no
Diabetic	☐ yes	☐ no	If yes, list medications: _____
Pregnant	☐ yes	☐ no	
Kidney Disease	☐ yes	☐ no	**Date of Lab Test:** **Bun:** **Creat:**

Procedure(s):

- ☐ Brain
- ☐ IAC
- ☐ Orbits
- ☐ Sinuses
- ☐ Mastoids
- ☐ Chest
- ☐ Kub
- ☐ Abdomen
- ☐ Pelvis
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine

Area of Interest _____

- ☐ Soft Tissue Neck
- ☐ Other _____

Patient History: _____

_____

Symptoms: _____

CC reports to: _____

Ordering MD Name: _____ Date: _____

Ordering MD Signature: _____ Phone: _____

FAX THIS REQUEST WHEN COMPLETED TO 983-8133

FORM # 31199 (Rev. 7/08) SR