

Multidetector CT Angiography at the Abington Memorial Hospital Schilling Campus Outpatient Imaging Center

Please complete and fax to 215-481-4899
CTA Scheduling Form

Patient Name: _____ DOB _____

Telephone #'s _____

Type of CTA (Specify body part): _____
Please be as specific as possible

Reason for exam: _____
Examples: pain, claudication ischemia, TIA ; Please do not use: Rule out..., Possible..., Family History of...

Referring Doctor and cc doctors: _____

Does patient have prior outside MRA, CTA or angiogram/arteriograms that are relevant to the CT exam being performed? _____ If Yes pt to bring with them to exam

Allergy to x-ray dye? – describe _____

If patient is mildly (hives) allergic to xray dye, has the patient been prepped? _____
Standard prep is Medrol 32mg po 12hrs and 2 hrs prior to study. If prior severe allergy to dye (difficulty breathing or shock), CTA should not be scheduled and radiologist should be contacted about alternative tests

BUN/Creatinine _____
Required within last 3 months for patients at risk for decreased kidney function

Procedure Prep - NPO for 4 hours prior to procedure - No oral contrast is given

To schedule please call CTA scheduling number or fax completed form and we will contact patient. Your patient may also call and we will contact you if we need additional information.

Contact Numbers:

CTA Scheduling Number: 215-481-5434
CTA Fax Number: 215-481-4899
Supervisor Number 215-481-5420

For Internal Use Only

Name of Radiology Dept Staff completing scheduling form _____

Name of approving technologist/radiologist: _____

Date of scheduled CTA _____ Reservation Number _____