Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

Tel: **705-327-9127** Fax: **705-330-3224**

REQUEST FOR

MRI Examination

• BY APPOINTMENT ONLY •

PATIENT INFORMATION | MRN N0.

APPOINTMENT DATE: **TIME:**

ARRIVAL TIME:

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER

Last Name | First Name | ☐ M ☐ F

Date of Birth (D/M/Y) | Health Card N0. | WSIB N0. | 3rd Party Ins. N0.

Address

City | Postal Code | Contact Number | **OK to leave voice mail message**

Patient is able to give consent for this procedure: ☐ Yes ☐ No

Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ SDM Name: ☐ SDM Contact Information:

☐ Patient requires assistance to complete this imaging exam, *e.g. mobility, translation* Please Specify:

ANATOMY TO BE SCANNED:

For MSK requests, please order general x-ray images of the affected joint if recent imaging has not been completed at OSMH.

CLINICAL QUESTION & RELEVANT CLINICAL HISTORY:

MRI Safety Assessment *Does the patient have any of the following:*

Previous Surgeries:	**When:**

Pacemaker *(absolute contraindication)*	☐ YES	☐ NO
Cerebral aneurysm clips *(absolute contraindication)*	☐ YES	☐ NO
Cochlear implants *(absolute contraindication)*	☐ YES	☐ NO
Brain Operation	☐ YES	☐ NO
Heart Operation	☐ YES	☐ NO
Prosthetic heart valve	☐ YES	☐ NO
Neurostimulator device	☐ YES	☐ NO
Insulin/chemotherapy pump	☐ YES	☐ NO
Coronary bypass graft / vascular stent	☐ YES	☐ NO
Any other metallic, magnetic or electronic implants?	☐ YES	☐ NO
Retained pacing wires	☐ YES	☐ NO
Shrapnel/ bullets	☐ YES	☐ NO
Ocular implant (cataract lens implant safe)	☐ YES	☐ NO
Penile implant	☐ YES	☐ NO
Tissue Expander	☐ YES	☐ NO
Ever had metal fragments in eyes?	☐ YES	☐ NO
If YES, send recent X-ray Orbit Report		
Is the patient pregnant?	☐ YES	☐ NO
Is the patient claustrophobic?	☐ YES	☐ NO
(If YES, physician to prescribe sedation)		
Allergic to MRI contrast?	☐ YES	☐ NO
Does the patient have mobility issues?	☐ YES	☐ NO

PATIENT WEIGHT: ☐ lbs ☐ kg **Maximum weight: 350 lbs**

PATIENT HEIGHT:

For Paediatric Use Only:

Is general anesthesia required? ☐ YES ☐ NO

Renal Function Assessment (please check appropriate box)

☐ Hx of Renal Disease ☐ Over 70 years ☐ On Dialysis

☐ Patient has NONE of the risk factors

If YES to any of the above, we require a current creatinine/eGFR in the last 2 months.

CREATININE LEVEL: CR _____ **eGFR** _____ **DATE:** _____

FOR DEPARTMENT USE ONLY PRIORITY: ☐P1 ☐P2 ☐P3 ☐P4

Signature:

☐ HEAD	☐ PELVIS	☐ ARTHROGRAM
☐ SPINE	☐ UPPER EXTREMITY	☐ CONTRAST
☐ NECK	☐ LOWER EXTREMITY	☐ FBO X-ray
☐ ABDOMEN	☐ CHEST	

Specify series required: ☐ Day Case (book between 8:00-16:00)

☐ ** NPO 4 Hours **

☐ ** NPO + Fleet Enema 6 hours prior to exam **

20	30	40	50	60	70	80

Physician's Name
(Please PRINT clearly)

Phone | **CPSO#**

Physician's Signature

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.