

MRI Consultation Request



Requisition received _____

Appointment _____

MRI Site _____

Patient Information

HC# _____ Province of coverage _____
 HC expiry date _____ DOB (yyyy/mm/dd) _____

NS-WCB# _____ Private Insurance Carrier _____
 Can Military# _____ Group# _____ Member# _____ Exp _____

Patient Name _____
Surname First Middle

Mailing Address _____

Telephone# _____ / _____ / _____
Home Cell Work

Patient Weight _____ kg or lb Gender _____

Ambulatory Wheelchair Stretcher Isolation

Safety Information (MUST be filled out completely)

Penetrating injury to eye involving metal, NOT yet cleared by an eye doctor or x-ray Y N
**If not cleared, please order orbit x-rays prior to MRI.*

Does patient work as grinder or welder Y N
**Orbit x-rays may be required prior to MRI.*

Attach details for implanted devices (Make, Model)

Pacemaker, internal defibrillator, leads Y N
 Cerebral aneurysm clips Y N
 Inner ear implants / cochlear implant Y N
 Eye surgery (detached retina, etc.) Y N
 Neuro, bio or spinal stimulator Y N
 Medication pump for insulin, chemo or pain Y N
 Orthopedic hardware / joint replacement Y N
 Any other implants (coils, filter, stent, mesh, pins, IUD, penile, pessary, etc.) _____

Shrapnel, bullet, bb, metal shaving in body Y N
 Previous relevant surgeries _____

Is the patient claustrophobic? Y N
**Oral sedation, if needed, must be prescribed by referring physician.*

Require general anesthetic Y N
 Is the patient pregnant? Y N
**If yes, number of weeks _____*

MRI Examination Requested

History and Provisional Diagnosis

Required information for CONTRAST MEDIA use

Renal disease Y N
 Currently on dialysis Y N
 Diabetic Y N

CREATININE _____ Date _____

Requesting Physician Information

PRINT NAME _____
 Telephone # _____
 Fax # _____
 Pager # _____
 Physician's SIGNATURE _____
 Date of request (yyyy/mm/dd) _____
 Copy of report to _____

INCOMPLETE FORMS WILL BE RETURNED, AND RESULT IN DELAYS FOR THE PATIENT

Additional Information is required before booking:

The safety information is not complete.
 Not legible
 Inadequate history
 No doctor signature
 Orbits not cleared yet
 Additional screening required for 3T MR

Radiologist Instructions Rad: _____

Priority P1 P2 P3 P4
 Magnet 1.5T 3.0T
Protocol _____
 Notes: _____

Technologist Instructions Tech: _____

Exam codes _____
 Time required for exam _____
 Notes: _____