London Health Sciences Centre

MRI REQUISITION

University Hospital Bookings
Telephone: 519-663-3088
Fax: 519-663-3544

Victoria Hospital Central Bookings
Telephone: 519-685-8770
Fax: 519-667-6826

PATIENT INFORMATION: (Plate)

Name: _____

PIN#: _____

DOB: _____

HC#: _____

Address: _____

Phone: _____

PHYSICIAN INFORMATION:

Print Name (with initials): _____

Signature: _____

Address: _____

_____

Telephone: _____ Fax: _____

☐ INPATIENT ☐ OUTPATIENT

WSIB:

Claim Number: _____

Date of Injury: _____

Employer Address: _____

_____

_____

☐ 3rd PARTY / INSURANCE

EXAMINATION REQUESTED: _____

Clinical Problem: (must be entered) _____

_____

_____

Please make sure all x-rays, bone scans, etc. pertaining to the area being scanned are sent prior to the MRI or with the patient.

MRI RESTRICTIONS: **<u>No patients</u> with implanted defibrillators or weight over 350 lbs or 159 kg.**
Most pacemakers and pacemaker leads are also contraindicated.

The following must be completed before the MRI will be booked.

1. Does the patient have a history of impaired renal function, or are they currently on dialysis? ☐ Yes ☐ No
2. Does the patient have hypertension? ☐ Yes ☐ No
3. Does the patient have diabetes? ☐ Yes ☐ No
4. Is the patient over 70 years of age? ☐ Yes ☐ No
   Creatinine Value: _____ Date (YYYY/MM/D): _____
   If you answered yes to any of the first 4 questions and your patient requires/or may require Gadolinium (MRI Contrast) a recent creatinine (<3 months) must be forwarded with the requisition.
5. Does the patient have any of the following implants or clips? ☐ Yes ☐ No
   ☐ Pacemaker ☐ Pacemaker Wires ☐ Defibrillator ☐ Vascular Filter
   ☐ GI Bleed Clip ☐ Carotid Artery Clamp
   ☐ Implanted Electronic Device ☐ Brain Aneurysm Clip ☐ Stents
   ☐ Programmable Shunts ☐ Embolization Coils
   If yes to any of the above, the following information is required.
   Make: _____ Model: _____ Date of Insertion: _____
   Description: _____
6. Has patient ever had metal in his/her eye? If yes, orbital x-ray required. ☐ Yes ☐ No
7. Is the patient pregnant? ☐ Yes ☐ No
8. Has the patient had previous surgery in the area of imaging? ☐ Yes ☐ No
9. Patient weight: _____ lb/kg
10. Any previous relevant MRI or CT? ☐ Yes ☐ No
    If yes where/when? _____
11. Does the patient require general anesthetic for their MRI exam? ☐ Yes ☐ No

Are you requesting a timed follow-up procedure (eg. 6 month follow-up)?

If yes, date requested: _____

MRI Exam Date:

-- Radiologist's Use Only --

Booking Priority:

☐ **1** Emergency
☐ **2** Urgent
☐ **2T** Urgent/Timed
☐ **3** Semi Urgent
☐ **3T** Semi Urgent/Timed
☐ **4** Non Urgent
☐ **4T** Non Urgent/Timed

Protocol

For more information on health services in the region, go to <u>www.thehealthline.ca</u>