



Name: _____
 HCN: _____
 Date of Birth: DD/MONTH/YYYY
 Address: _____
 Street/Town/Postal Code
 Telephone: _____
 Inpatient – Unit _____ Outpatient
 Patient Transport: Bed Stretcher Wheelchair
 MCP WCC NR DVA DND Other: _____

Physician Information (please use stamp)

The ordering physician is responsible to follow-up on the exam report.

Physician Signature: _____
 Date: DD/MONTH/YYYY
 Copy report to (please print): _____

Type of Exam Required

Specific Exam Requested: _____

Please indicate whether exam is being requested for a specific site or first available appointment. Please note that requesting a specific site may result in a longer wait time.
 First Available Specific Site (indicate site): _____

Please Identify Urgency

Based on clinical assessment, Radiologist consult may be indicated.

Urgent
 Non-urgent
 Follow-up (Specify Date): DD/MONTH/YYYY
 Screening (Specify Date): DD/MONTH/YYYY

Clinical Information

Is patient on Warfarin, ASA or other anticoagulant? Yes No
 Is patient receiving Metformin or Glucophage? Yes No
 Please list any other relevant patient medications:

Has patient received IV contrast in the past? Yes No
 Has patient had an adverse reaction to IV contrast? Yes No
 Does the patient have contact precautions? Yes No
 Is the patient claustrophobic? Yes No
 Height: _____ Weight: _____
 Please list allergies: None _____

Clinical Diagnosis: _____

Clinical Indications for Exam (including previous relevant exams):

Safety Checklist

Please indicate if patient has any of the following:

Cardiac pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aneurysm clip(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implanted cardioverter defibrillator (ICD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Electronic or magnetic implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cochlear, otologic, or other ear implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart valve prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyelid spring or wire	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metallic stent, filter or coil	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shunt (spinal or intraventricular)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IUD, diaphragm or pessary	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tattoo, permanent makeup or dermal piercing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injury by a metallic object or foreign body	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other _____		

Complete for exams requiring IV Contrast:

Are there any of the following risk factors for nephrogenic systemic fibrosis (NSF)? Yes No

Risk Factors: Dialysis, renal transplant, single kidney, renal surgery, renal cancer, hypertension requiring medical therapy and diabetes mellitus.

If risk factor is present, provide patients current* estimated GFR: _____ Date of last GFR: DD/MONTH/YYYY

*Outpatient: less than 6 weeks (outpatients with eGFR of less than 44 mL / min/1.73 m2 less than 48 hours); Inpatient: less than 48 hours

For Diagnostic Imaging Use Only

Ordering Physician Notified: Phone Message Mail Exam Protocol: _____
 Date Received: DD/MONTH/YYYY
 Patient Preparation Instructions: Yes No
 Patient Notified: Phone Message Mail
 IV Contrast: Yes No Sedation: Yes No