Eastern Health
Diagnostic Imaging

# Request for Magnetic Resonance Imaging (MRI)

IV1580 0777 01 2015

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 | ❑ Yes | ❑ No |
| Aneurysm clip(s) | ❑ Yes | ❑ No |
| Implanted cardioverter defibrillator (ICD) | ❑ Yes | ❑ No |
| Electronic or magnetic implant | ❑ Yes | ❑ No |
| Cochlear, otologic, or other ear implant | ❑ Yes | ❑ No |
| Heart valve prosthesis | ❑ Yes | ❑ No |
| Eyelid spring or wire | ❑ Yes | ❑ No |
| Metallic stent, filter or coil | ❑ Yes | ❑ No |
| Shunt (spinal or intraventricular) | ❑ Yes | ❑ No |
| IUD, diaphragm or pessary | ❑ Yes | ❑ No |
| Tattoo, permanent makeup or dermal piercing | ❑ Yes | ❑ No |
| Injury by a metallic object or foreign body | ❑ Yes | ❑ 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*

*Date Received:* DD/MONTH/YYYY

*Patient Preparation Instructions:* ❑ *Yes* ❑ *No*

*Patient Notified:* ❑ *Phone* ❑ *Message* ❑ *Mail*

*IV Contrast:* ❑ *Yes* ❑ *No* *Sedation:* ❑ *Yes* ❑ *No*

*Exam Protocol:* _____

_____

_____

_____

_____