Soldiers' MEMORIAL HOSPITAL Orillia

REQUEST FOR
MRI Examination
• BY APPOINTMENT ONLY •

Tel: **705-327-9127** Out-Patient Fax: **705-330-3224** In-Patient Fax: **705-325-0582**

PATIENT INFORMATION

MRN N0. | Isolation Status

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ED ☐ AHF

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

Email Address | 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 AND RELEVANT CLINICAL INFORMATION
(Must be provided and must be specific)

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

Pacemaker or ICD	☐ YES	☐ NO
Cochlear Implants	☐ YES	☐ NO
Cerebral Aneurysm Clips or Coils	☐ YES	☐ NO
Loop Recorder	☐ YES	☐ NO
Brain Operation	☐ YES	☐ NO
Heart Operation	☐ YES	☐ NO
Prosthetic Heart Valve	☐ YES	☐ NO
Neorostimlulator/Biostimulator	☐ YES	☐ NO
Insulin/Chemotherapy Pump	☐ YES	☐ NO
Coronary Bypass Graft/ Vascular Stent	☐ YES	☐ NO
Any other metallic, magnetic or electronic implants?	☐ YES	☐ NO
Other Stent	☐ YES	☐ NO
Retained Pacing Wires	☐ YES	☐ NO
Shrapnel/Bullets	☐ YES	☐ NO
Penile Implant	☐ YES	☐ NO
Breast Tissue Expander	☐ YES	☐ NO
Spinal Fusion	☐ YES	☐ NO
Artificial Limb/Joint	☐ YES	☐ NO

If YES to any of the above, provide details in the space to the right

Ever had metal fragments in eyes that have not been previously removed by a physician?	☐ 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 provide sedation

Is the patient allergic to MRI contrast?	☐ YES	☐ NO

PATIENT WEIGHT: ☐ lbs ☐ kg PATIENT HEIGHT:

For Paediatric Use Only:
Is general anesthesia required? ☐ YES ☐ NO

Renal Function Assessment (please check appropriate box)

☐ Hx of Renal Disease ☐ 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:** _____

List All Previous Surgeries: **When:**

Physician's Name (Please PRINT clearly) | **Phone #** | **CPSO #**

Address | **Fax #**

Physician's Signature

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