Thunder Bay Regional Health Sciences Centre

Diagnostic Imaging

# MAGNETIC RESONANCE IMAGING (MRI)

CONSULTATION REQUEST

**Is the patient hearing impaired?** ☐ **Yes** ☐ **No**
**Regional Inpatient?** ☐ **Yes** ☐ **No**
**Requires Hoyer Lift?** ☐ **Yes** ☐ **No**

**Guidelines:**

1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. Fax requisitions including Regional referrals to Diagnostic Imaging Central Intake **855-978-1862.**

Patient Name: _____ ☐ In-Patient ☐ Out-Patient

Address: _____ Date of Birth _____ /_____ /_____
day month year

_____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____ Sex: ☐ Male ☐ Female

Health Insurance Card Number: _____ Version Code: _____

Workplace Safety and Insurance Board (WSIB) Claim Number: _____

Areas to be scanned: ☐ Brain ☐ Abdomen ☐ Spine ☐ (specify) _____
☐ Thorax ☐ Pelvis ☐ Other ☐ (specify) _____
☐ Breast (must also complete Breast MRI Additional Information Form #FCS - 297 )

Clinical Information: _____

_____

_____

Patient Height_____ Patient Weight _____

| **Does the patient have any of the following:** | **Yes** | **No** |
|---|---|---|
| Pacemaker | ☐ | ☐ |
| Surgical Aneurysm Clips | ☐ | ☐ |
| Cochlear (Middle Ear Implants) | ☐ | ☐ |
| Prosthetic Heart Valve Replacement | ☐ | ☐ |
| Neuro Stimulator Device | ☐ | ☐ |
| Metal Fragments In Eye | ☐ | ☐ |
| Implanted Insulin/Chemotherapy Pump | ☐ | ☐ |
| May Be Pregnant | ☐ | ☐ |
| Claustrophobia (no sedation provided) | ☐ | ☐ |
| Glucose Monitor Patch | ☐ | ☐ |

| **RELEVANT PREVIOUS STUDIES:** | **Date** | **Where** |
|---|---|---|
| ☐ MRI (Magnetic Resonance Imaging) Scan | _____ | _____ |
| ☐ CT (Computerized Tomography) Scan | _____ | _____ |
| ☐ Angiography | _____ | _____ |
| ☐ X-Ray | _____ | _____ |
| ☐ Nuclear Medicine | _____ | _____ |
| ☐ Ultrasound | _____ | _____ |

**PRIORITY ASSESSMENT:**

☐ **1** – **Immediate** - Emergent
☐ **2** – **Within 48 Hours** - Inpatient/Urgent
☐ **3** – **Within 10 Days** - Semi-urgent
☐ **4** – **Within 4 Weeks** - Non-urgent

**Clinical Indication for Scan**

☐ Breast Cancer Screening
☐ Cancer Staging and/or Diagnosis
☐ Other

**RADIOLOGIST NOTES:**

**Protocol:**

? Intravenous Contrast:

Urgency: 1 2 3 4

**Scheduler Use Only**

Appointment Date: _____ / _____ / _____
day month year

**Physician's Name (please print):** _____

**Physician's Signature:** _____ **Date:** _____