Thunder Bay Regional Health Sciences Centre

Diagnostic Imaging

MAGNETIC RESONANCE IMAGING (MRI)

CONSULTATION REQUEST

Patient Name:_____

D.O.B. (YYYY-MM-DD):_____

Address:_____

City/Town, Prov:_____

Postal Code: _____Tel: _____

Health Card #: _____Version: ____

Place Patient Label with Barcode HerePlace

Is the patient hearing impaired? ☐ **Yes** ☐ **No**
Regional Inpatient? ☐ **Yes** ☐ **No**
Requires Hoyer Lift? ☐ **Yes** ☐ **No**
Does patient require an interpreter? ☐ **Yes** ☐ **No**

Guidelines:

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

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

Healthcare Provider's Name (please print): _____

Healthcare Provider's Signature: _____ **Date:** _____