Magnetic Resonance Imaging (MRI)

CONSULTATION REQUEST

GUIDELINES FOR USE: Regional Inpatient? Yes ☐ No ☐

1. Healthcare Provider to complete requisition. Incomplete requisitions will be returned.
2. Fax requisitions to Diagnostic Imaging Central Intake: 1-**855-574-0821**
3. If there is relevant prior imaging from outside facilities, please provide reports with requisition.

Patient Name: _____
D.O.B. (YYYY-MM-DD):_____
Address: _____
City/Town, Prov: _____
Postal Code: _____
Health Card #: _____Version: ____
Telephone: ( ) _____
Alternate: ( ) _____

Is the patient hearing impaired? Yes ☐ No ☐ **Does patient require an interpreter?** Yes ☐ No ☐
Mobility Needs? Yes ☐ No ☐ **Is NHIB used for travel arrangements?** Yes ☐ No ☐

MRI Exam Requested – Please be specific / specify levels

☐ Brain ☐ Abdomen ☐ Spine (specify) _____
☐ Thorax ☐ Pelvis
☐ Breast (must also complete Breast MRI additional Form #FCS-297)
☐ Prostate
☐ Other (specify) _____

Patient Height_____**Patient Weight**_____

CENTRAL INTAKE (FOR P2-P4 PRIORITY)

Is the patient willing to travel for the shortest wait time?
Yes ☐ **No** ☐

Which site is the patient willing to have their appointment at?

Kenora Lake of the Woods District Hospital ☐
Thunder Bay Regional Health Sciences Centre ☐

Clinical Information

_____
_____
_____
_____
_____

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

Does the patient have any of the following:

	Yes	No
Pacemaker	☐	☐
Surgical Aneurysm Clips	☐	☐
Cochlear (Middle ear implants)	☐	☐
Neuro Stimulator Device	☐	☐
Metal Fragments in Eye	☐	☐
Implanted Insulin/Chemotherapy Pump	☐	☐
May be pregnant	☐	☐
Claustrophobia (no sedation provided)	☐	☐

Relevant Previous Treatments/Studies	**Date**	**Where**
☐ MRI (Magnetic Resonance Imaging)	_____	_____
☐ CT (Computed Tomography)	_____	_____
☐ Ultrasound	_____	_____
☐ X-Ray	_____	_____
☐ Nuclear Medicine	_____	_____
☐ Angiography	_____	_____

Healthcare Provider_____

Referring Site or Clinic_____

Copy Report to_____

Healthcare Provider's Signature *x*_____

Date_____

Priority (P) Assessment

☐ P1 -Immediate – Emergent ****See instructions below****
☐ P2 -Within 48 Hours-Inpatient/Urgent ****See instructions below****
☐ P3 -Within 10 Days - Semi-Urgent
☐ **P**4 -Within 4 Weeks - Non-Urgent
☐ Greater than 4 Weeks – Specify Date _____

** For **P1-P2** requests; please contact the site in which the request will be completed at and contact the radiologist on call for approval:

- TBRHSC Switchboard 807-684-6000 press 0
- Kenora Switchboard 807-468-9861 press 0

INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.

FCS-001 Approved Rev Jan 2004; Rev Sept 2006; Rev Dec 2006, June 2011, Mar 2012, Jan 2022, Jan 2023, May 2023, May 2025