

**REQUEST FOR MRI CONSULTATION**

**IN-PATIENT** MRN Number: \_\_\_\_\_ Floor \_\_\_\_\_ Room # \_\_\_\_\_ ER \_\_\_\_\_  **OUT-PATIENT**

Surname: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: (h) \_\_\_\_\_ (m) \_\_\_\_\_  
 Health Card (HIN): \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)  
 Gender: Female  Male  Other   
 Weight: \_\_\_\_\_ lbs/kg -> Table limit is 550lbs/250kg  
 WSIB (Claim #): \_\_\_\_\_  
 Employer: \_\_\_\_\_

**Mobility:** Stretcher  Wheelchair  Walk  O2   
**Isolation:** Airborne  Droplet  Contact

**Referring Physician:**  
 Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_  
 Copy Report to: \_\_\_\_\_  
 Copy Report to: \_\_\_\_\_

**INCOMPLETE or ILLEGIBLE requisitions will be returned and will DELAY Study**

Examination requested: \_\_\_\_\_

Indication/Reason and Related Clinical Information:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is the patient Claustrophobic? No  Yes  If Yes, the ordering MD is to prescribe a medication prior to arrival

Any allergies to **contrast dye**? No  Yes  If Yes, please list \_\_\_\_\_

→ If allergy to Gadovist specifically, please follow premedication guidelines.

**If the patient has renal impairment, you MUST provide a recent eGFR (within the last 6 months) as per CAR guidelines. No Bloodwork needed in patients with normal renal function, i.e., expected eGFR of 30 ml/min**

eGFR: \_\_\_\_\_ mL/min Date Drawn: \_\_\_\_\_

**PLEASE COMPLETE THE PATIENT SAFETY SCREENING**

	No	Yes		No	Yes
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Shrapnel/Bullets	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobic	<input type="checkbox"/>	<input type="checkbox"/>	Surgical aneurysm clip	<input type="checkbox"/>	<input type="checkbox"/>
Requires sedation	<input type="checkbox"/>	<input type="checkbox"/>	Coils, filters, grafts, shunts, or stents	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker, defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Cochlear implant	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Medical patches, sensors	<input type="checkbox"/>	<input type="checkbox"/>
Vascular access port, catheter	<input type="checkbox"/>	<input type="checkbox"/>	Previous Eye Injury, Metallic foreign body *	<input type="checkbox"/>	<input type="checkbox"/>
Previous Gadolinium	<input type="checkbox"/>	<input type="checkbox"/>			

\* If yes, referring physician to order X-Ray of orbits and submit report with requisition.

**FOR RADIOLOGIST USE ONLY:**

PROTOCOL: \_\_\_\_\_

Additional Sequences: \_\_\_\_\_

Priority: 1 2 3 4

Gadolinium: No  Yes

Radiologist signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)